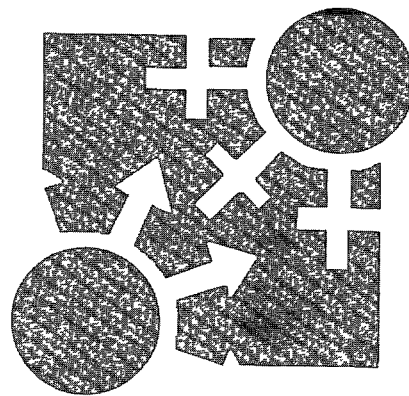


PN - ACK - 907
108231

Research Gaps Related to Gender Issues and Population, Health, and Nutrition Programs:

AN ANALYSIS

April 2000



**Research and Indicators Subcommittee
Interagency Gender Working Group**

Table of Contents

Acknowledgments	ii
Reviewers.....	iii
I. Introduction	1
II. “Gender-Sensitive” Reproductive Health Research	3
A. Characteristics of Gender-Sensitive Research	3
B. Intervention Research Attempting to Change Gender Roles	5
III. Research Gaps	7
A. Adolescents	7
B. Behavior Change Communications.....	11
C. Child Survival	15
D. Environmental and Occupational Health	18
E. Female Genital Cutting	21
F. HIV/AIDS/STIs and Condom Use	24
G. Infectious Diseases and Reproductive Health	28
H. Infertility.....	30
I. Postabortion Care	33
J. Postmenopausal Women.....	37
K. Quality of Care	40
L. Reproductive Health and Reproductive Rights	44
M. Safe Motherhood	52
N. Violence Against Women	55
O. Other Topics	58
IV. Priorities Matrix	59

Acknowledgments

This research gaps analysis was prepared by the Research and Indicators Subcommittee of the Interagency Gender Working Group. Karen Hardee and Jill Gay developed the framework (matrix) for the gaps analysis, Nancy Williamson prepared the section on what constitutes gender sensitive research, and Karen Hardee and Anne Peterson edited the final version of this document. Members of the Research and Indicators Subcommittee prepared each section, and members of the wider reproductive health community (listed in next section) reviewed the document.

Funding for preparation of this document was provided by the United States Agency for International Development (USAID). The views expressed by the authors do not necessarily reflect the views or policies of USAID.

This document may be reproduced and distributed for noncommercial and nonprofit purposes without prior consent from the authors.

Reviewers

The authors would like to thank the following people for their time, consideration of the issues, and thoughtful comments when reviewing either the entire document or specific sections:

Reviewed Entire Document

Felice Apter, USAID
Sarah Harbison, USAID
Mihira Karra, USAID
Jeff Speiler, USAID
Kirstin Vogelsong, USAID

Reviewed Specific Section(s)

Adolescents

Kate Bond, FOCUS
Nancy Murray, FOCUS
Anne Wilson, PATH

Behavior Change Communication

Jodi Jacobson, CHANGE
Amy Bank, Puntos de Encuentro
Gary Lewis, CCP/Johns Hopkins
University
Alice Welbourn, Consultant

Child Survival

Neal Brandes, USAID

Female Genital Cutting

Nahid Toubia, RAINBO New York

HIV/AIDS/STIs/Condoms

Mabel Bianco, Latin American and
Caribbean Council of AIDS Service
Organizations
Tim Frasca, Corporacion Chilena de
Prevencion de SIDA
Mihira Karra, USAID
Jeff Spieler, USAID
Ellen Weiss, Horizon

Infertility

Ulla Larsen, Harvard School of Public
Health, Harvard University

Postabortion Care	Deborah Billings, Ipas
Postmenopausal Women	Peg Marshall, CEDPA
Quality of Care	Judith Helzner, IPPF/WHO
Reproductive Rights	Rebecca Cook, University of Toronto Richard Strickland, ICRW.
Safe Motherhood	Miriam Labbok, USAID Leslie Elder, MotherCare/JSI Marge Koblinky, MotherCare/JSI

I. Introduction

The fields of population, health, and nutrition are increasingly recognizing that gender, or the socially defined roles and status of women and men in societies and the relative power women and men have associated with their roles, is an important determinant of women's and men's reproductive health. Gender analyses have shown that reproductive health problems and services affect women differently from the way they affect men. As family planning programs expand to include more components of reproductive health, many are seeking to do so using a gender perspective. Trying to meet both women's and men's practical needs for health care and their strategic needs (whatever women need to overcome subordination related to safeguarding their reproductive health and rights in a particular social context) are part of taking a gender perspective in reproductive health programs.

Simply acknowledging that a gender perspective is important, however, does not provide clear guidance on how to make changes in programs. Research, including biomedical, policy/programmatic, and social science studies, can help programs make changes that empower women and men to exercise their reproductive rights and meet their reproductive goals and to promote gender equity.

Biomedical research includes studies of the physical, medical, and technological aspects of reproductive health. Policy and programmatic research includes studies of policies, guidelines and regulations and the service delivery system and practices that support reproductive health services. Social science research includes studying the sociocultural dynamics of reproductive health choices, practices and outcomes. In addition, gender considerations can affect the way research is carried out.

The subcommittee on research and indicators of the USAID Population, Health and Nutrition (PHN) Interagency Gender Working Group has outlined what constitutes gender-sensitive research for reproductive health and has compiled a list of research gaps related to the reproductive health and rights aspects of the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW).¹ This report lists the gaps in research—in the areas of biomedical, policy/programmatic, social science research, and in the research process—and then presents a short bibliography of research studies on the topic that best exemplify a gender perspective.

¹ This analysis does not include men's reproductive health as a separate component because the IGWG has a separate subcommittee on men that has compiled its own list of research gaps.

The topics identified from ICDP and FWCW (developed in section III. below) include, in alphabetical order:

- Adolescents.
- Behavior change communications [on human sexuality, sexual and reproductive health, and responsible parenthood, including on effective prevention of sexually transmitted infections (STIs) and HIV, and the factors which increase the risks of developing cancers and infections of the reproductive tract].
- Environmental health (especially the effects on women).
- Child survival.
- Female genital cutting (active discouragement of any violence against women and harmful practices such as female genital cutting).
- HIV/AIDS/STIs and other conditions of the reproductive tract (prevention, diagnosis, and treatment) and condom use (promotion, supply, and distribution of high-quality condoms).
- Infectious diseases.
- Infertility (prevention and treatment).
- Postabortion care (prevention and management of complications of unsafe abortion).
- Postmenopausal women (information and services).
- Quality of care (in family planning counseling; information, education, communication; and services).
- Reproductive rights (including the right to choose family size; have access to services; attain the highest standard of sexual and reproductive health; and make decisions free of discrimination, violence, and coercion).
- Safe motherhood (prenatal, safe delivery, and postnatal care, including breastfeeding).
- Violence against women (medical and mental services for girls and women/boys and men who have experienced any form of violence).
- Miscellaneous.

Research priorities for the topics listed above have been compiled into a matrix for easy comparison (provided at the end of this document).

II. "Gender-Sensitive" Reproductive Health Research

In the area of reproductive health, there is general agreement that research should attempt to be "gender-sensitive." But what does this mean? To further this dialogue, we propose some ideal characteristics of gender-sensitive research, whether intervention research, survey research, or more qualitative research.

A. Characteristics of Gender-Sensitive Research

1. Research Design and Conceptualization

Gender-sensitive research uses a gender analytic framework to frame the research questions. This might include one of the more formal gender analytic frameworks, for example, Moser (1989), Oppong (1980) or the Women's Studies Project (Hardee et al., 1996),² or could just involve thinking through potential gender issues thoroughly before proceeding.

Gender-sensitive research also:

- Looks at the lives of males and females in a holistic way, considering their options, quality of life, experiences, and perceptions and power relations between men and women. Gender issues are relevant to understanding reproductive health providers as well as their clients and client-provider interactions.
- Considers how, in a given setting, gender roles vary by age, social and economic status, ethnicity, religious affiliation, and other social characteristics.
- Seeks to involve both women and men as study participants as well as researchers.
- Encourages women and men to speak for themselves about topics of interest to them.
- Is attentive to relations between and among men and women including differences in status, power and roles, vulnerability, access to resources, physical traits, and family relations.

²Moser, CO. 1989. "Gender Planning in the Third World: Meeting the Practical and Strategic Gender Needs." *World Development*. 17(11): Pp. 1799-1825. Oppong, C. 1980. "A Synopsis of Seven Roles and Status of Women: An Outline of a Conceptual and Methodological Approach." *World Employment Programme Research Working Paper*. WEP 2-21/WP.94. Geneva: International Labour Office. Hardee, K, P Ulin, S Pfannenschmidt and C Visness. 1996. "The Impact of Family Planning and Reproductive Health on Women's Lives: A Conceptual Framework." *Women's Studies Project Working Paper WP96-02*. Research Triangle Park, NC: Family Health International.

- Views women and men as part of families and communities rather than solely as individuals.
- Recognizes that relations between women and men often change over time and can differ according to women's and men's life-cycle stages (e.g., in some societies, older women are accorded higher status than younger women).
- Is aware that relationships between women and men can vary by situation and activity (e.g., women may have power to make certain kinds of decisions but not others).
- Involves women and men not only as respondents but whenever possible, in study design, implementation, and interpretation of results. Involving women's (or men's) health advocates can be especially helpful in making sure the research is relevant and sensitive to people's experiences.

2. Data Collection

Some of these characteristics of gender research could be considered general principles of good ethical research. The ethical issues are included here because they are so closely tied to gender issues.

Gender-sensitive research:

- Investigates topics that are relevant to local needs and problems, not just those of interest to the investigator.
- Considers whether gender training would be beneficial for research staff including interviewers.
- Acknowledges the power differences between researchers/interviewers and study participants as well as between providers and clients and that these differences can lead to poor treatment on the part of the less powerful party.
- Does not burden study participants in terms of the time required, scheduling of interviews, or invasiveness of questions; each question asked should have a purpose and be essential to the analysis.
- Incorporates, where possible, multiple methods of data collection, including qualitative data to allow women and men to tell their stories in their own words.
- Pretests all study instruments to make sure that questions are clear and sensitively worded.
- Does not just collect data for the sake of professional publications but to improve the welfare of study participants.
- Considers whether compensation of study participants is appropriate and if so, what level of compensation would be fair but not coercive.
- Puts a strong emphasis on informed consent (whether oral or written) and the need to respect the privacy and confidentiality of any information provided. All the research staff (interviewers, clerks, drivers, etc.) and not just the principal investigator need to be imbued with a concern for protection of human subjects.
- Explains to potential respondents that their participation is voluntary, they will suffer no negative consequences if they do not participate, and they do not have to answer any question they feel is inappropriate.

3. Data Analysis

Gender-sensitive research uses the terms “gender” and “sex” thoughtfully with the former referring to the socially constructed roles expected of males and females, while the latter refers to biologically determined characteristics.

4. Dissemination

Gender-sensitive research:

- Makes a “good faith” effort to convey the research findings back to study participants in a user-friendly fashion, ideally using multiple approaches.
- Disseminates results to people in a position to improve local conditions.

B. Intervention Research Attempting to Change Gender Roles

Some intervention research in the area of reproductive health has more explicit gender-related goals, such as testing approaches to enrolling and keeping more girls in school or to making women more aware of their rights or to encouraging more men to seek reproductive health services for themselves or for their partners. Some intervention research seeks to improve provider-client interactions, while others seek to get couples to better communicate about reproductive health issues or to use male or female condoms for STI/HIV prevention. The above suggestions should apply to research whether it deals directly or indirectly with gender issues.

III. Research Gaps

When reading this list of research gaps, keep in mind that *gender* was the main focus of the analysis. Thus, for each topic the analysis does not include an exhaustive list of studies needed on the topic but only the research questions related to gender and the topic.

A. Adolescents

Prepared by Nancy Yinger, PATH

By endorsing the Cairo Programme of Action at the International Conference on Population and Development (ICPD) and the Beijing Platform at the Fourth World Conference on Women (FWCW), the global community has resolved to “protect and promote the rights of adolescents to sexual and reproductive health information and services” (UN 1994; UN, 1995). Family planning and sexually transmitted infection (STI) prevention were seen as central but insufficient components of reproductive health for adolescents that should include: counseling and services for sexually active married and unmarried adolescents; antenatal and postpartum care; sex education and information for the prevention of STIs and HIV/AIDS; counseling on gender relations, violence, and sexual abuse against adolescents, and responsible sexual behavior for both sexes; confidential mental health services for youth who have experienced any form of violence; and prevention and treatment of abuse and incest (UN, 1994).

The UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural context of their lives, but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold uncompromising attitudes toward adolescent sexual behavior. Moreover, current adolescent programs often do not include all segments of the youth population. Two categories in particular are often excluded: 1) those who are out-of-school or most at risk, such as street children and teenage sex workers, and 2) married adolescents. Even though adolescent childbearing outside marriage is increasing, the majority of births to adolescents are still to married adolescents. Unfortunately, it is often assumed that once an adolescent is married, the usual vulnerabilities do not apply. Yet, these young women share age and parity risk factors and many of the social risk factors including being vulnerable to sexual violence and unaware of good health-seeking behavior.

In many parts of the world, the sexual behavior of adolescents is rapidly changing, promoted by relaxation of traditional norms governing premarital

sexual behavior, migration (particularly rural to urban, but also intraregional, and transnational migration), and exposure to mass media. In those countries where the age of sexual initiation is decreasing and less rigid attitudes toward and sanctions against premarital sexual relationships are emerging, early sexual experience now places adolescents at high risk for unintended pregnancy and sexually transmitted infections, including HIV/AIDS. In parts of the world that have remained more isolated, young people, many of whom are married, also face significant health risks stemming from poor knowledge of reproductive health issues and low status as females. Because of age, immature physiology and gender, young women—both married and unmarried—are particularly vulnerable to exploitation that in turn leads to significant reproductive health problems. Issues for further research include:

Biomedical Research

- To what extent does the immature female genital tract make adolescent girls more susceptible to STIs and inadequate bone development make them more susceptible to pregnancy-related complications?

Policy/Programmatic Research

- What barriers do young women face in using modern-sector reproductive health services (government, NGO and commercial) for family planning, STI, safe motherhood and/or PAC services? Do service providers particularly discriminate against young, unmarried, sexually active women? What barriers do young men face in using modern sector reproductive health services for family planning or STIs? Are the barriers faced by young men different than those faced by young women? Do very young adolescents face different barriers than older adolescents?
- To the extent that governments have adopted the ICPD framework, have they included adolescent women in their programming efforts?
- Have governments adopted a human rights framework that includes a focus on the particular vulnerabilities of young people, such as sexual coercion or, for women, female genital mutilation? If so, how is it being implemented?
- What are the best intervention strategies that meet the needs for both information and services of various categories of adolescents, desegregated by sex where appropriate: 1) sexually active teens who are not pregnant, both married and unmarried; 2) pregnant or parenting teens, both married and unmarried; 3) those suffering from consequences of harmful traditional practices that may affect their reproductive outcomes (for example, female genital mutilation); 4) those in special circumstances such as teens living in refugee settlements, and those at risk of sexual exploitation; 5) teens with little or no education living in low resource settings; and 6) very young adolescents.
- How do fees for service affect adolescent women's and men's use of reproductive health services differently?

Social Science Research

- How are gender norms, especially related to sexuality, changing around the

world? What factors influence those norms? What is the link between gender norms and adolescent reproductive health outcomes?

- Do adolescent women and men make decisions differently about reproductive health-related issues? What is the balance between individual calculations and outside influences for males and females?
- Most research on adolescents reproductive health issues focuses on individual characteristics. Yet the social environment and peer groups are known to be very influential in terms of adolescent behavior. Are adolescent women and men affected differently by their peers in terms of behaviors that put their reproductive health at risk?
- Many adolescent women have sexual partners who are significantly older than they are; what are the implications for adolescent women's reproductive health if there is a large age gap between them and their sexual partners? Do age and gender norms compound the vulnerabilities of young women and how can this be addressed (what audiences need to be reached to improve the situation)?
- What reproductive health services do adolescent women and men perceive they need? Have adolescent women and men been involved in the research process in a participatory way, with researchers using both qualitative and quantitative techniques to get an in-depth understanding of the needs?

The Research Process

- If researchers avoided certain topics because of their perceived sociocultural sensitivity, like adolescent women's sexuality, how can future research be supported and improved to gain a better understanding of gender-related adolescent reproductive health issues?
- Do researchers interested in adolescent reproductive health "buy into" social norms that are punitive toward sexually active girls but understanding of sexually active boys? And do these attitudes shape their research agendas?

Selected Bibliography

- Adamchak, Susan, et. al. Review Draft, July 1999. "A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs." Washington, DC: FOCUS on Young Adults.
- Birdthistle, I. and Vince-Whitman C. 1997. "Reproductive Health Programs for Young Adults: School Based Programs." *Focus on Young Adults Research Series*. Washington, DC: Pathfinder International.
- The Alan Guttmacher Institute. 1998. *Into A New World: Young Women's Sexual and Reproductive Lives*. New York: The Alan Guttmacher Institute.
- Hughes, J. and McCauley AP. 1999. "Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries." *Studies in Family Planning*, 29(2):233-45.
- Israel RC and Nagano R. 1997. "Social Marketing and Media Communications Programs for Young Adult Reproductive Health: A Review of Trends and Practices." Draft, *Focus on Young Adult Research Series*. Washington, DC: Pathfinder International.

- Population Reference Bureau (PRB). 1996. "The World's Youth." Washington, DC: PRB.
- Senderowitz J. 1997a. "Health Facility Programs on Reproductive Health of Young Adults." *Focus on Young Adults Research Series*. Washington, DC: Pathfinder International.
- , 1997b. "Reproductive Health Outreach Programs for Young Adults." *Focus on Young Adults Research Series*. Washington, DC: Pathfinder International.
- United Nations. 1994. *Report of the International Conference on Population and Development*. Cairo, Egypt.
- , 1995. *The Official Report of the Fourth World Conference on Women*. Beijing, China.
- World Health Organization. 1999. "Reproductive rights of adolescents: the role of social science research." *Progress in Human Reproductive Research*, No. 50.

B. Behavior Change Communications

Prepared by Rebecca Firestone, CHANGE

As the field of reproductive health is shifting in response to the ICPD and the global women's movement, so too are approaches to health communication within reproductive health programs. While some communication programs and strategies continue to view their audiences as instrumental to achieving specific health objectives, such as increased contraceptive prevalence rates, a newer generation of programs is taking a broader approach, seeking to influence social and cultural norms that shape behavior, build skills to foster behavior change, and use educational strategies to cultivate a sense of power and entitlement among individuals and communities. Rather than viewing individuals as targets of specific messages, such efforts view women and men as active participants in analyzing information and adopting certain attitudes, values, and behaviors. Because behavior change communication (BCC) programs try to affect the normative environment which influences behavior, these programs can contribute to women's empowerment, fostering a process that challenges gender relations within communities and societies.

As a strategy in promoting reproductive and sexual health and rights, behavior change communication may have somewhat different implications for women and men, depending on the health issue to be addressed. But whether a communication program works at the interpersonal, community, or mass media level (or at a mix of levels), we need to ask who participates in the design, implementation, and evaluation of the program, and we need to look at the assumptions made about gender norms. To further refine the ability of behavior change communication to improve reproductive health and foster gender equity, research is needed to look at how existing BCC programs address and affect gender norms. Formative research is also needed to develop new communications programs that can create a sense of entitlement to reproductive health and rights among participants. On a more basic level, we need to better understand the process of change on an individual, community, and policy level. Some issues for further research and testing of interventions include:

Policy/Programmatic Research

- How do existing behavior change communication programs address gender roles and status in the communities and societies where they are in place? What effects do BCC programs have on existing gender norms within communities and societies?
- How do BCC programs with women's empowerment and gender equity components address or defuse potential community resistance? How successful are communications programs that focus on changing or clarifying values in support of gender equity?
- Do BCC programs provide information or messages on body awareness and reproductive functioning for women and men?
- What effects do BCC programs have on existing gender norms within communities and societies?

- How successful are communications programs that focus on changing or clarifying values in support of gender equity?
- How are target audiences identified, and how well are these audiences involved in identifying the objectives of BCC strategies?
- How can smaller-scale BCC programs and campaigns conducted by local NGOs and civil society organizations be scaled up to reach a larger audience?
- Have the strategies of local NGOs and civil society organizations been documented, and have innovative techniques been evaluated?
- How are secondary audiences (women and men, men and women, providers and clients) affected or influenced differently by gender-related assumptions within BCC programs? Have these effects been measured?
- How can sexuality research be better incorporated into the design of BCC strategies and programs?
- How can human rights education and consumer advocacy strategies be integrated into the design of BCC programs?
- What communication and organizing skills do women need to demand high quality health information and services?
- What techniques and processes have been used in eliciting the participation of previously under-represented groups (e.g. women, adolescents, ethnic minorities) in the design, implementation, and evaluation of BCC programs, and have these techniques been evaluated?
- Can large-scale BCC programs/campaigns be designed with process components that allow participants to redesign elements of the program objectives as the program develops?
- Have multilevel BCC programs or campaigns been evaluated and compared against programs that use only one level of communication?
- Do women respond differently to multilevel versus unilevel BCC programs?
- Do women have a greater need for behavior change interventions that focus on fostering a sense of self-efficacy and entitlement than men?
- What indicators exist to measure changes in values and norms in the process of changing behaviors?
- What process and outcome indicators exist to measure changes in gender norms as a result of BCC programs?
- Does the incidence of violence against women within target communities increase when BCC strategies link reproductive health and women's empowerment?
- Are BCC programs that integrate a range of women's health concerns more successful in fostering behavior change than programs that focus on a specific behavioral intervention?

Social Science Research

- How do mass media, as used in reproductive health and social marketing programs, affect gender images and norms?

- How do the political and social factors necessary to create a supportive environment for behavior change differ between women and men?
- Does the process of behavior change differ between women and men? Are some theories of behavior change more applicable to women than men or vice versa?
- How do women in various societies perceive sexuality, reproduction, and family roles and responsibilities?
- How do men in various societies perceive sexuality, reproduction, and family roles and responsibilities?
- How do measures of self-efficacy differ between women and men?

The Research Process

- Who participates in the research necessary to design and evaluate BCC programs?
- When community participation is an expressed goal in the design and evaluation of BCC programs, are gatekeepers and community leaders the primary participants, or are women and other traditionally less powerful groups within a community also involved?
- When pretesting materials, how do women contribute to feedback and evaluation of the materials? Do they give input or are they fundamentally involved in design?

Selected Bibliography

- Bank A. 1997. "Communication Strategies for the Empowerment of Women and Young People in Nicaragua: Some Lessons Learned," presented at *Changing Communication Strategies for Reproductive Health and Rights*, the Working Group on Reproductive Health and Family Planning, Washington, DC, December 10-11, 1997.
- Boonmongkon, Pimpawan, et al. 1998. *Developing a Culturally Acceptable Model of Integrated Reproductive Health Care for Rural Women*. Center for Health Policy Studies, Mahidol University, Salaya, Thailand.
- Chandiramani R. 1998. "Talking About Sex." *Reproductive Health Matters*. 6(12): 76-86.
- Denison J. 1996. *Behavior Change – A Summary of Four Major Theories*. Arlington, Virginia: Family Health International/AIDSCAP.
- Glanz K and Rimer BK. 1995. *Theory at a Glance: A Guide for Health Promotion Practice*. Washington, DC: US Department of Health and Human Services, Public Health Service.
- Murphy E. 1997. "A Quick History of Health Communication." Presented at *Changing Communication Strategies for Reproductive Health and Rights*, the Working Group on Reproductive Health and Family Planning, Washington, DC, December 10-11, 1997.
- National Institutes of Health. 1991. *Factors Influencing Behavior and Behavior Change: Theorist's Workshop, Excerpts from the Final Report*. October 3-5, 1991, Washington, DC.

- Riehman KS, Sly DF, Soler H, Eberstein IW, Quadagno D, Harrison DF. 1998. "Dual- Method Use Among an Ethnically Diverse Group of Women at Risk of HIV Infection." *Family Planning Perspectives*. 30(5): 212-217.
- Tilson Piotrow P, Kincaid DL, Rimon JG, and Rinehart W. 1997. *Health Communication: Lessons from Family Planning and Reproductive Health*. Westport, CT: Praeger.
- Welbourn A. 1997. "Incorporating Gender Issues into Community AIDS Prevention Programs: the Stepping Stones Methodology," presented at *Changing Communication Strategies for Reproductive Health and Rights*, the Working Group on Reproductive Health and Family Planning, Washington, DC, December 10-11, 1997.

C. Child Survival

Prepared by Jill Gay and Anne Peterson, Consultants

Child survival has received considerable attention from the international development community, which has paved the way for programs targeting preventative services in the community, such as immunization, water purification, sanitary practices; and preventative caretaker behaviors, such as breastfeeding and hygiene. Still, more attention needs to be paid to gender issues and their impact on child survival, and many areas of research have yet to be addressed.

Gender disparities between girls and boys and how this affects their differential health profiles, both during childhood and later in the life cycle, have yet to be fully explored. Both the health and the quality of life of girls is lower than that of boys in many developing countries. "Gender disparities exist before birth and become wider through the school age and adolescent years, although the nature and extent of the disparities may vary from country to country." (UNICEF, 1991) The benefits of programs that specifically address gender disparities and provide girls with opportunities for education, sexuality education and improved health and nutrition need to be documented as girls grow older and enter adulthood. In addition, many undocumented childhood health hazards affect both boys and girls, such as pesticide exposure. Pesticide exposure may potentially have negative reproductive health consequences when the child reaches puberty and later in the life cycle. The long-term outcomes of such hazards to children should be the subject of future research. Issues that need further research include:

Biomedical Research

- How do pharmacological differences in medications for girl children as compared to boy children affect reproductive health later in life?
- Does pesticide poisoning during childhood lead to adverse reproductive health problems later in the life cycle?
- What treatment strategies are most appropriate for pregnant HIV positive women? What factors inhibit mother-child transmission of HIV/AIDS?
- When is the most effective timing for specific nutritional interventions in female children, adolescents, and women to influence the woman's health, the weight of offspring and in turn the health status of the next generation of offspring?

Policy/Programmatic Research

- What are ways of encouraging communities to reduce gender inequities in order to improve girls' nutrition?
- How does attention to gender in child health lead to improvements throughout the life cycle?
- What programs and policies have been effective in reducing sex trafficking against girl children?

- What are effective ways for health services to encourage gender equitable treatment of girl and boy children? Specifically,
- When children are gathered for immunization, how can community members and health workers be motivated to seek out the girls, who may be at home?
- How can health services be changed to encourage outreach to girl children for necessary prevention and care?
- What can encourage mothers/fathers/teachers/community members important to children to be knowledgeable about and discuss the issues of sexuality and the psychological/physiological/emotional changes that occur during puberty?
- What are effective ways to teach mothers/fathers/teachers/community members important to children the knowledge they need to discuss sexuality/puberty?
- What programs encourage boys to learn fathering and nurturing of children at an early age? Does this have any measurable impact when boys become fathers?
- What programs and policies have been effective in reducing sex selection of the boy fetus?
- What are effective ways for health services to encourage fathers to nurture and provide primary health care in the household for children?
- Does the sex of a newborn child and overt gender preference have an effect on the birth interval? Specifically, if a girl child is born but a boy child was wanted, is the interval between the next birth shortened?

Social Science Research

- What factors contribute to inequitable health resources for girls as compared to boys?
- What factors lead to uneven/inequitable distribution of food in the household? What impact does this have on reproductive health later in life? What programs can best effect change in this area?
- What IEC/training can motivate mothers/fathers/communities to encourage equal opportunities for girls, including schooling? Equal access to health care and/or nutritional requirements?
- What kind of (psychological) support does the mother of a girl child need when there is a formal celebration of birth when the child is a boy, but nothing for the girl?
- What are the long-term psychological implications for girl children who are unwanted?
- How can communities be encouraged to change cultural practices and gender norms (e.g., fasting in the last month of pregnancy) to enable pregnant women to have a nutritionally appropriate diet?

Selected Bibliography

Kurz KM and Prather CJ. 1995. *Improving the Quality of Life of Girls*. New York, NY: UNICEF.

Institute of Medicine (IOM). 1996. *In Her Lifetime: Female Morbidity and Mortality in Sub-Saharan Africa*. Washington, DC: National Academy Press.

World Bank. 1994. *A New Agenda for Women's Health and Nutrition*. Washington, DC.

D. Environmental and Occupational Health

Prepared by Jill Gay, Consultant

Gender issues related to environmental and occupational health have received little attention to date. The major foci for USAID's work in environmental health has been diarrheal disease, malaria, and acute respiratory infections. However, many major environmental health issues which affect the reproductive health of millions of people have important implications for a gender perspective:

- Pesticide exposure among men, women, and male and female children who work in the fields planting and harvesting crops.
- Exposure to hazardous wastes.
- Occupational exposures to environmental hazards in assembly and manufacturing plants and other industrial settings.

A WHO report estimated that 3 to 5 million people worldwide suffer from acute pesticide poisonings each year; other estimates are as high as 10 million. Recent news reports have exposed the transfer of hazardous waste from Taiwan to Cambodia, with no information for the local population concerning contamination, health risks, and reproductive outcomes. The World Bank estimates that between 400 million and 700 million women and children are exposed to severe air pollution, in most instances from cooking fires (WRI, 1998), but little is known about whether this has any impact on reproductive health, particularly pregnancy and incidence of miscarriages. Research on these issues has often lacked a gender perspective.

Biomedical Research

- How does the prevalence of anemia in women impact on the reproductive health risks of environmental and occupational exposures?
- Are there any reproductive health impacts from exposure to air pollution?
- What are the physiological differences in reproductive organs of men and women, as well as of girl and boy children, which will cause differential health effects from a particular exposure, either to pesticides or other chemicals? If a pregnant woman is subject to a particular exposure, what will be the effect on the male/female infant? What will be the effect later in that infant's life when he/she reaches adolescence and adulthood? Will there be any reproductive health outcomes?

Policy/Programmatic Research

- What are the most effective ways to provide women and girl children, particularly those who are illiterate, with training concerning the reproductive health hazards of pesticide exposure?
- What are effective ways to train health service providers to recognize and treat occupational, environmental or pesticide-related etiologies during reproductive health care?
- What are effective ways to reduce the incidence of sexual harassment for working women?

- How can health services become more effective in meeting the reproductive, environmental and occupational health needs of migrant farmworker women and girls?
- What legislative initiatives have been successful in protecting pregnant women from undue occupational or task-related exposures to pesticides or hazardous chemicals without discriminating against women in the workplace? What legislative initiatives and/or legal cases have been successful in protecting men from contamination-induced unwanted sterility?

Social Science/Epidemiology Research

- What are the numbers of women and girl children at risk of pesticide exposure with concomitant reproductive health risks? Which crops, tasks, gendered roles and pesticides place women and girls most at risk? Men and boys?
- Which occupational and domestic tasks involve differential reproductive health risks for women and men?
- What are the reproductive health hazards associated with different *maquila* (sweatshops) or other occupational industry exposures where women are predominantly employed?

The Research Process

- What mechanisms can ensure that environmental health research considers a gender perspective?
- What are effective ways to involve the affected populations in the research being conducted, particularly the women?
- What are effective ways to communicate the research findings to all stakeholders, particularly the women in the affected communities? (IOM, 1999)

Selected Bibliography

- Burg J, Gist G. "Observations from the CDC: The Potential Impact on Women from Environmental Exposures." *Journal of Women's Health*. 6(2): 159-161.
- Colburn T, Dumanoski D, Peterson Myers J. 1996. *Our Stolen Future: Are We Threatening Our Fertility, Intelligence, and Survival? A Scientific Detective Story*. New York: Dutton.
- Dankelman I, Davidson J. 1988. *Women and the Environment in the Third World: Alliance for the Future*. London: Earthscan.
- Doyal L. *What Makes Women Sick: Gender and the Political Economy of Health*. 1995. New Brunswick, NJ: Rutgers University Press.
- Gladen B, Rogan W. DDE and Shortened Duration of Lactation in a Northern Mexican Town. *American Journal of Public Health*. 85(4): 504-508.
- Guillette E, Mercedes Meza M, Aquilar M, Soto A, Garcia I. 1998. "An Anthropological Approach to the Evaluation of Preschool Children Exposed to Pesticides in Mexico." *Environmental Health Perspectives*. June, No. 106: pp. 347-353.
- Huisman M, Koopman-Esseboom C, Fidler V, Hadders-Algra M, van der Pauw CG, Tuinistra LG, Weisglas-Kuperus N, Sauer PJ, Townen BC, Boersma ER.

1995. "Perinatal Exposure to Polychlorinated Biphenyls and Dioxins and Its Effect on Neonatal Neurological Development." *Early Human Development*. 41(2): 111-127.
- Institute of Medicine (IOM). 1999. *Environmental Justice: Research, Education, and Health Policy Needs*. Washington, DC: National Academy Press.
- . 1998. *Gender Differences in Susceptibility to Environmental Factors: A Priority Assessment*. Washington, DC: National Academy Press.
- Lopez Carillo L. 1996. "Is DDT Use a Public Health Problem in Mexico?" *Environmental Health Perspectives*. 104(6): 584-588.
- Misner S. 1995. *Occupational Issues in Women's Health*. New York, NY: National League for Nursing Press. Vol. II.
- Moses M, Johnson E, Anger W, Burse V, Horstman S, Lewis R, Maddy K, McConnell R, Meggs W, Zahm S. 1993. Environmental Equity and Pesticide Exposure. *Toxicology and Industrial Health*. 9(5): 913-959.
- Rodda A. 1994. *Women and the Environment*. New Jersey: Zed Books.
- Steingraber S. 1997. *Living Downstream: An Ecologist Looks at Cancer and the Environment*. New York: Addison-Wesley Publishing Company, Inc.
- US Public Health Service's Office on Women's Health and the Society for the Advancement of Women's Health Research. *Women's Health and the Environment: Innovations in Science and Policy*. Washington, DC. Sept. 10, 1998.
- Wiltshire R. 1992. *Environment and Development: Grassroots Women's Perspective*. Barbados: Development Alternatives with Women for a New Era.
- World Resources Institute (WRI), The United Nations Environmental Programme (UNEP), The United Nations Development Programme (UNDP), and the World Bank. 1998. *World Resources 1998-1999, A Guide to the Global Environment: Environmental Change and Human Health*. New York: Oxford University Press.
- Zahm S, Ward M, Silverman D. 1998. "Occupational Cancer: Chapter 39." In: Edited by Marlen Goldman and Maureen Hatch, *Women and Health*. Academic Press: In Press.

E. Female Genital Cutting

Prepared by Asma Abdel Halim, Population Fellow, USAID

Female Genital Cutting (FGC) is a harmful traditional practice that has existed for thousands of years and continues to be performed to this day. The ritual comprises a variety of surgeries that include clitoridectomy, excision, and infibulation.³ These operations are performed on girls at different ages, ranging from a few days old to puberty.

The research done on FGC so far has concentrated on how it is done, its prevalence, and attitudes towards this practice. Gender relations and the social construct within which women's sexuality and reproduction has been controlled has rarely been addressed, and serious consideration of including men in the debate to stop the practice came only a few years ago. Bringing men into this dialogue will help not only in the efforts to stop FGC, but also in supporting women's rights to their sexuality and bodily integrity. Men's participation in the elimination efforts will help create a harmonious movement toward the recognition of women's rights to their bodily integrity; involving men is also important because they monopolize the religious discourse.

Although the health consequences of FGC are paramount among the reasons for fighting it, and are the first to be researched, there are gaps in the research, namely:

Biomedical Research

- What is the relationship between FGC and transmission of HIV/AIDS?
- What are the long-term physical effects of FGC for women?
- What is the actual mortality rate as a direct result of FGC? Indirect (such as increased HIV/AIDS transmission)?
- What are the long-term psychological effects of the practice on women and their male partners?
- Do the views that emphasize the psychological trauma make women feel less human by treating them as psychologically broken and in need of treatment? In other words, if women are actually traumatized is it because of FGC or because of others' attitudes towards them?
- What is the relationship between infertility and FGC?
- What indigenous health knowledge/skills/practices of traditional birth attendants would aid FGC healthcare programs most? What is the best way to impart this knowledge?

Policy/Programmatic Research

- What is the relationship between family planning and FGC?
- What are the consequences of dealing with FGC in isolation from other gender issues?

³ For more information on classification see Female Genital Mutilation, Report of the WHO Technical Group, 1996.

- What are the advantages and/or disadvantages of dealing with FGC as part of an overall empowerment program?
- How can the existing FGC programs be evaluated for effectiveness?
- Why does funding for FGC programs remain inadequate and disproportionate to the size and gravity of the problem?
- What is the real cost of treating the health consequences of FGC?
- Which is best for women and more helpful for the elimination movement: to have country-wide policies for education and elimination or to have criminal codes to punish those who practice or to have both educational programs and a law at the same time?

Social Science Research

- Is there a difference in the way men and women approach the issue of FGC? How do we address each?
- Is there male reluctance to get involved in combating FGC?
- What are the appropriate steps to deal with FGC as a religious issue?
- What are the gender issues that set FGC apart from other mutilating practices in the practicing communities?
- What is the effect of the law on eradication efforts?

The Research Process

- What effect do the different status and somewhat different gender roles of Western researchers have on the methods of FGC research?
- Will bringing in the power of men to eradicate FGC disempower women in any way? If so, what is the best way to deal with this?
- What are the appropriate tools and means of research for FGC in each community?
- How can the language and specific terminology of FGC research effect the value of this research?

Selected Bibliography

- Abdel Halim A. 1995. "Rituals and Angels." In: *From Basic Needs to Basic Rights*, editor Margaret Schuler. Washington, DC: Institute for Women Law and Development.
- Al-Sabbagh ML. 1997. *Islamic Ruling on Male and Female Circumcision*. Geneva: World Health Organization.
- Battlefields of Women's Bodies: The Political Controversy over FGM in Egypt*. A packet of articles on and documents from the current legal controversies over FGM in Egypt. New York: RAINBO.
- Boddy J. 1990. *Wombs and Alien Spirits: Women, Men and the Zar Cult in Northern Sudan*. Madison, Wisconsin: University of Wisconsin Press.
- Breakthrough in Senegal: Ending Female Genital Cutting*. 1999. Dakar, Senegal: Population Council.
- Dorkenoo E. 1994. *Cutting The Rose: Female Genital Mutilation: The Practice and its Prevention*. London: Minority Rights Publications.

- Intersections Between Health and Human Rights 1996: A Case of Female Genital Mutilation*. Report from a one-day workshop at the National Council on International Health (NCIH) in 1995. New York: RAINBO.
- Shell-Duncan B, Ylva H, eds. 2000. *Female Circumcision in Africa: Culture, Controversy and Change*. Boulder, Colorado: Lynne Rienner Publishers.
- Toubia N, Izett S. 1998. *Female Genital Mutilation: an Overview*. Geneva: World Health Organization.
- . 1998. *Learning about Social Change*. New York: RAINBO.
- Wasif N. 1998. *Dah min Zaman*. Cairo, Egypt: Task Force Against Female Genital Mutilation.

F. HIV/AIDS/STIs and Condom Use

**Prepared by Jill Gay, Consultant, and Nancy Williamson,
FRONTIERS/Population Council/FHI**

Gender issues related to HIV/AIDS are manifold and complex. In many societies, women lack the power to make decisions about how, when and under what conditions they wish to engage in sexual relationships, which can place them at risk for HIV/AIDS. Many women fear violence if they deny their sexual partner(s) unprotected sex, but for women, unprotected sexual relationships are key to economic survival for themselves and their children. Worldwide, millions of women are at risk of HIV largely because their only sexual partner may have multiple partners; yet these women have been largely ignored in public policy, such as the World Bank's *Confronting AIDS: Public Priorities in a Global Epidemic* (1997).

In many societies, sexual knowledge is taboo for women before the initiation of sexual intercourse. Most of the world's health services have yet to effectively incorporate information on STIs and HIV/AIDS prevention, intervention, management, diagnosis, testing, and counseling into programs that reach out to women who may be at risk yet are not considered high risk. Commercial sex workers have traditionally been seen as vectors of transmission rather than deserving of health services, yet few health programs address the needs of commercial sex workers or offer them training to pursue other means of economic survival (Kilmarx, 1998). Studies have shown that HIV risk reduction efforts, with outreach to women separately prior to interaction with men, can be effective, either in community-wide efforts or as part of small group interventions (Gupta and Weiss, 1998; Ickovics, 1998). The challenge is to provide these interventions on a large enough scale to prevent the currently 12.1 million women infected with HIV from continuing to grow in numbers, and to provide humane and effective care for those who are already infected.

Biomedical Research

- What incentives might prompt pharmaceutical companies to develop more products to meet women's needs for cheap, easy methods to detect asymptomatic STIs?
- What incentives might prompt pharmaceutical companies to develop more products to meet women's needs to prevent HIV without a partner's knowledge or consent?
- How can progress to develop a cheap, easy to use mechanism to identify cervical infections be accelerated?
- How can progress in developing a microbicide be accelerated? How can progress in developing an improved cheaper female condom be accelerated?
- Are sufficient funds allocated for the R&D of microbicides and female condoms?
- What product can be developed, or how can male condoms be improved, in order to increase sexual pleasure for both partners and be easier to use while reducing risk of transmission of HIV and STIs?

- Does syndromic management of STIs lead to an increase in drug resistant strains of STIs?

Policy/Programmatic Research

- What are effective ways to involve women and their sexual partners in HIV risk reduction and to maintain risk reduction practices over sustained periods of time?
- How can the norms of sexual behavior be changed so that:
 - men, women, and their sexual partners can discuss sexual relationships prior to intercourse?
 - nonconsensual sexual relationships are reduced?
 - women can initiate and enjoy sexual relationships? risk of acquiring STIs and HIV is reduced?
- What is the most effective way to provide nonpunitive, noncoercive health services to commercial sex workers that will not result in stigmatization?
- What are effective ways to train health providers to counsel sexual partners to improve communication, promote gender equity, reduce nonconsensual sex, reduce the risks of STIs and HIV, and provide male and female barrier methods?
- What are effective ways for sexually active women at risk of STIs and HIV (yet who may be asymptomatic and not identify themselves as “at risk”) to receive information, diagnosis and treatment concerning STIs and HIV in health services? How and at what level should services be integrated?
- Under what conditions is syndromic management effective and does not result in antibiotic resistance or recurring symptoms? Is counseling, coupled with self-screening, effective in empowering women to demand detection and treatment for STIs? How does women’s perceived risk following counseling compare with actual risk for reproductive tract infections (RTIs)?
- What policies and programs are most effective in combating the stigmatization of those who are HIV positive? In combating the stigmatization of men having sex with men?
- What are effective policies and programs, such as food donations, education waivers, revolving loans, hospice care, etc., to mitigate the impact of AIDS on households and/or families and reduce women’s disproportionate burden of care for those who are HIV+?
- What programs and policies are effective in reducing the incidence of violence and abuse between sexual partners?
- Which programs and policies will enhance women’s social and economic status and thus reduce the need for accepting money or goods in exchange for sex?
- What are effective ways for HIV prevention interventions to incorporate discussions of attitudes and beliefs concerning sexuality and sexual relationships and/or encounters? What are effective ways to reach boys and girls, separately or together, prior to the initiation of sexual activity, particularly those who are too poor and/or isolated to attend school? What are effective ways to provide RTI services to adolescents?

- What policies and programs will encourage those who are HIV+ to serve as peer educators? What types of care and support enable those who are HIV+ to become advocates for prevention?
- What are effective ways to train providers to detect and counsel women on RTIs and HIV in a helpful, nonjudgmental way which will empower women and increase gender equity?
- What are effective ways to increase the numbers of male STI and HIV patients who will refer their female sexual partners for testing and counseling?
- What are different approaches to increase sustained and successful condom use in different sub-populations, such as adolescents, heterosexuals, homosexuals, ethnic groups?
- What approaches work best to help women negotiate condom use? Can the community-based, interactive program in Uganda called Stepping Stones be successfully adapted for other populations?
- Despite the high cost of the female condom, can the female condom be successfully promoted as a back up method when male partners object to the use of the male condom? Can the female condom be used without the knowledge and consent of their partner?

Social Science Research

- What are the differences between successful and unsuccessful condom users; both female and male condoms, both heterosexual and homosexual?
- Do gender issues inhibit the use of condoms used in conjunction with other methods?
- How can women be empowered with economic alternatives to commercial sex work?
- What is the most effective way to provide nonpunitive, noncoercive health services to commercial sex workers that will not result in stigmatization?
- What factors contribute to nonconsensual sexual relationships?
- How can the changes in increasing condom usage achieved among men having sex with men be transferred to men having sex with women?
- Are there effective ways for HIV+ women to reveal their seropositive status to their partners without fear of violence or abuse?
- How do couples integrate condoms into their sexual relationship? Who is responsible for purchasing condoms? Who decides to use condoms? How is the decision made? Are condoms used in conjunction with other methods? Are condoms used with regular partners or with non-regular partners?

The Research Process

- What mechanisms can ensure that biomedical research and clinical trials consider a gender perspective, both in the research process and in the product being tested?
- What is the most effective way for women's health advocates to participate in the setting of biomedical research priorities in order to ensure that

women's research is carried out with an understanding of the gender issues involved?

Selected Bibliography

These references are key sources which incorporate a gender perspective on HIV/AIDS and STIs.

- Corporacion Chilena de Prevencion del SIDA. 1997. *De Amores y Sombras: Poblaciones y Culturas Homo y Bisexuales en Hombres de Santiago*. Santiago, Chile.
- Farmer P. 1996. "Women, Poverty and AIDS," in: *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence*, edited by Paul Farmer, Margaret Connors, and Janie Simmons. Monroe, Maine: Common Courage Press.
- Forsythe S and Rau B. 1998. "Evolution of Socioeconomic Impact Assessment of HIV/AIDS". *AIDS Supplement 2*: S47-S55.
- Germain A, Holmes K, Piot P, and Wasserheit J. 1992. *Reproductive Tract Infections: Global Impact and Priorities for Women's Reproductive Health*. NY: Plenum Press.
- Heise L and Elias C. 1995. "Transforming AIDS Prevention to Meet Women's Needs: A Focus on Developing Countries." *Social Science and Medicine*. 40(7): 931-943.
- Heise L, Moore K and Toubia N. 1995. *Sexual Coercion and Reproductive Health: A Focus on Research*. New York: Population Council.
- Ickovics J And Yoshikawa H. 1998. "Preventive Interventions to Reduce Heterosexual Risk for Women: Current Perspectives, Future Directions." *AIDS*. 12, Supplement A: S197-S208.
- Institute of Medicine. 1997. *The Hidden Epidemic: Confronting Sexually Transmitted Diseases*. Eng TR and Butler WT, Eds. Washington, DC: National Academy Press.
- Kilmarx P, et al. 1998. "HIV-1 Seroconversion in a Prospective Study of Female Sex Workers in Northern Thailand: Continued High Incidence Among Brothel-Based Women." *AIDS*. 12(14): October.
- Vuylsteke B, Sunkutu R and Laga M. 1996. "Epidemiology of HIV and Sexually Transmitted Infections in Women," in: *AIDS in the World II: Global Dimensions, Social Roots, and Responses*. The Global AIDS Policy Coalition, edited by Jonathan M. Mann and Daniel J.M. Tarantola. New York, New York: Oxford University Press.
- Weiss E, Whelan D and Gupta GR. 1996. *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World: Findings from the Women and AIDS Research Program*. Washington, DC: International Center for Research on Women.
- Wingood G, and DiClemente R. 1997. "The Effects of an Abusive Primary Partner on Condom Use and Sexual Negotiation Practices of African-American Women." *American Journal of Public Health*. 87(6): 1016-1018.
- de Zoysa I, Sweat M, and Denison J. 1996. "Fearful but Faithful: Reducing HIV Transmission in Stable Relationships." *AIDS (Supplement A)*: S197-S203.

G. Infectious Diseases and Reproductive Health

Prepared by Jill Gay, Consultant

Gender issues related to infectious diseases and reproductive health have received little attention within USAID. However, other international organizations and development agencies, such as Canadian International Development Agency (CIDA) and the World Health Organization's Tropical Disease Research (WHO/TDR), have paved the way in research concerning gender and infectious disease. For USAID, the challenge will be to take the gender-related research completed by agencies such as CIDA and WHO/TDR and apply it to their initiatives.⁴ For example, tuberculosis is now the single biggest infectious killer of women in the world, due in part to increased rates of HIV and the correlation between TB and HIV. There are important gender aspects to certain research questions that have yet to be addressed, as applying a gender perspective to infectious disease is a relatively new and uncharted challenge.

Biomedical Research

- How can the increased susceptibility of pregnant women to malaria be reduced?
- What are the long-term health effects over several generations of using impregnated bed nets, especially for reproductive health outcomes? (Colburn, 1996)
- Does exposure to DDT used to combat malaria (in what amounts, under what conditions, etc.) lead to an increased risk of breast cancer? Other reproductive health effects in women? If women are pregnant and exposed to DDT, what will be the impact on the future health of the fetus?
- What is the biologic interaction between malaria infection and HIV infection during pregnancy? What does this mean for treatment?

Policy/Programmatic Research

- What are effective ways to give women and girls knowledge of infectious diseases, especially malaria, prior to their first pregnancy?
- What are cost-effective ways to reduce the number of mosquitoes that carry malaria while at the same time using less DDT (which is known to increase the risk of breast cancer)?
- What are effective ways to provide at risk pregnant women with anti-malaria drugs in cases where women either do not attend antenatal care clinics or present for antenatal care very late in pregnancy?
- What legislative initiatives have been effective in allowing working women to breastfeed? What nutritional programs have been effective in providing women adequate nutrition for both themselves and for breastfeeding?

⁴ USAID. 1999. "Reducing the Threat of Infectious Diseases of Major Public Health Importance: USAID's Initiative to Prevent and Control Infectious Diseases."

Social Science Research

- What training is effective to promote male support for breastfeeding and male involvement to reduce women's traditional chores to enable breastfeeding?
- What are current beliefs among different populations concerning infectious diseases, such as malaria and TB, during pregnancy? Are these beliefs different for men and for women? Are patterns of drug distribution different for men and for women for malaria, TB, or other infectious diseases, especially when a woman is pregnant?

Selected Bibliography

- Institute of Medicine (IOM). 1998. *Gender Differences in Susceptibility to Environmental Factors: A Priority Assessment*. Washington, DC: National Academy Press.
- . 1996. *In Her Lifetime: Female Morbidity and Mortality in Sub-Saharan Africa*. Washington, DC: National Academy Press.
- Wijeyaratne P, Rathgeber E, St-Onge E. 1992. *Women and Tropical Diseases*. Ottawa, Canada: The International Development Research Centre and the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR).

H. Infertility

Prepared by Karen Hardee, POLICY Project, The Futures Group International

Infertility is one of the most neglected aspects of reproductive health, and yet the ability to conceive, carry and produce a child is the focal point of reproductive health for most women worldwide. It is estimated that 1 in 12 couples worldwide has difficulty conceiving a child. In some parts of the developing world, particularly in parts of Africa, the incidence of infertility due to the prevalence of STIs is even higher. The assumption that infertility treatments are too expensive to offer to the general public, coupled with the reluctance of many people who are facing infertility to speak out on the issue, have combined to take infertility off the table in discussions of packages of reproductive health services in most countries. The gender issues related to infertility include: 1) attitudes towards women's and men's contribution to infertility (generally women are "blamed" for the infertility problem); 2) attitudes towards women who seek fertility treatments (that they become somehow unbalanced); and 3) the different treatment of women who are unable to conceive and their partners (who are not assumed to be the cause of the infertility in most societies). In many societies, women can be divorced or the husband may take another wife if they are unable to produce children in a union.

Biomedical Research

- What types of clinical trials for infertility treatments are being undertaken in developing countries?
- What research is being done to study the effects of women's and men's exposure to environmental pollutants on fertility? More specifically, is exposure to endocrine disrupters identified as a source of infertility for both men and women?
- Are inexpensive treatments recognized and equally available for both female and male factor infertility (such as penicillin for the main STIs gonorrhea and chlamydia)?
- What research is being done to distinguish the dominant factors of infertility in developing countries?
- Are there any promising leads in discovering causes for unexplained infertility?
- What are the biomedical reasons for higher fetal loss and lower fertility of women with HIV+/AIDS? While there is some research in this area, further analyses are needed.

Policy/Programmatic Research

- To what extent are STIs recognized as causes of infertility for both women and men?
- How does gender influence access to inexpensive treatments for both female and male factor infertility (such as penicillin for the main STIs gonorrhea and chlamydia)?

- What are the most promising efforts being made to reduce STIs, PID and associated infertility in women and men in various countries? What populations are they reaching? How successful are these efforts?
- What are the effects of harmful traditional practices, such as female genital cutting/female circumcision, on the woman's ability to bear children?
- What health care seeking behaviors, i.e., the use of modern versus traditional medicine and belief in witchcraft and/or other traditional regimens, are associated with infertility?
- Are any reasonably inexpensive ways of extending infertility diagnosis and treatment being studied in developing countries?
- What are the prevailing attitudes of health care providers toward infertile women and men in various countries?
- How much are clients willing to pay for infertility diagnosis and treatment in various countries?
- What are elements of effective programs, including information campaigns, that eliminate the social stigma and sometimes harmful consequences, especially to women, associated with infertility?
- What is the role of family planning and reproductive health programs in helping to develop guidelines for use of assisted reproductive technologies in various countries?
- What, if any, is the ethical obligation of family planning and reproductive health programs to include care for infertile women and men as part of their programs?
- Why are more insurance policies covering the costs of Viagra for men rather than infertility treatments for women and men? What assumptions are behind this decision on the part of insurance companies?

Social Science Research

- What are the social consequences of infertility for women and men in various societies? What are women's, men's and families' coping strategies for dealing with infertility in various countries?
- What are the perceptions of various groups (policymakers, opinion leaders, providers, the public) of the causes of and treatments for infertility?
- What is the link between the value men and women place on fertility and use of various contraceptive methods?
- What are the perceptions regarding male infertility in various countries?
- Is there a link between infertility and child fostering and/or adoption?

Selected Bibliography

Biomedical

- Birenbaum-Carmeli D, Carmeli YS, Casper RF. 1995. "Discrimination Against Men in Infertility Treatment." *The Journal of Reproductive Medicine*. 40(8): 590-594.
- Cates Jr. W, Rolfs RT, Aral SO. 1990. "Sexually Transmitted Disease, Pelvic Inflammatory Disease, and Infertility: An Epidemiologic Update." *Epidemiological Review*. 12:199-219.

- Gray R, Wawer M, Serwadda D et al. 1998. "Population-Based Study of Fertility in Women with HIV-1 Infection in Uganda." *Lancet*. 351:98-103.
- Khanna J, Van Look PFA, and PD Griffin, Eds. 1994. "Prevention of Infertility," in *Challenges in Reproductive Health Research*. Biennial Report 1992-1993 of the UNDP/UNFPA/WHO/ WORLD BANK Special Programme of Research, Development and Research Training in Human Reproduction. Geneva: World Health Organization.
- LaVertu DS and AML Parada. 1993. "Assessing the New Techniques for Assisted Reproduction: A Gender Perspective." In Gomez, EG, Ed. *Gender, Women, and Health in the Americas*. Scientific Publication No. 541. Washington, DC: Pan American Health Organization.
- Programmatic**
- Fiander A. 1990. "Infertility: An Approach to Management in a District Hospital in Ghana." *Tropical Doctor*. July.
- Halman LJ, A Abbey, and FA Andrews. 1993. "Why are Couples Satisfied with Infertility Treatment?" *Fertility and Sterility*. 59(5): 1046-1054.
- Okonofua FE. 1996. "The Case Against New Reproductive Technologies in Developing Countries." *British Journal of Obstetrics and Gynecology*. 103: 957-962.
- Vekemans M. 1994. "Is the Treatment of Infertility a Luxury in a World in the Middle of a Population Expansion?" *Entre Nous*. No. 25.
- Sundby J, Mboge R and S Sonko. 1998. "Infertility in the Gambia: Frequency and Health Care Seeking." *Social Science and Medicine*. 46(7): 891-899.
- Van Voorhis BJ, Sparks AET, Allen BD, Stovall DW, Syrop CH, Chapler FK. 1997. "Cost-Effectiveness of Infertility Treatments: A Cohort Study." *Fertility and Sterility*. 67(5): 830-836.
- Social Science**
- Callan VJ. 1987. "The Personal and Marital Adjustment of Mothers and of Voluntary and Involuntary Childless Wives." *Journal of Marriage and the Family*. No. 49. November. Pp. 847-855.
- Feldman-Savelsberg. 1994. "Plundered Kitchens and Empty Wombs: Fear of Infertility in the Cameroonian Grassfields." *Social Science and Medicine*. 39(4): 463-474.
- Inhorn MC. 1994. "Interpreting Infertility: Medical Anthropological Perspectives," *Social Science and Medicine*. 39(4): 459-461.
- 1994. "Kabsa (A.k.a. Mushahara) and Threatened Fertility in Egypt," *Social Science and Medicine*. 39(4): 487-505.
- 1994. *Quest for Conception. Gender, Infertility and Egyptian Medical Traditions*. University of Pennsylvania Press.
- Larson U. 1994. "Sterility in Sub-Saharan Africa." *Population Studies*. No. 48. Pp. 459-474.
- Neff D. 1994. "The Social Construction of Infertility: The Case of the Matrilineal Nayars in South India." *Social Science and Medicine*. 39(4): 475-485.
- Okonofua FE, Harris D, Odebiyi A, Kane T, Snow RC. 1997. "The Social Meaning of Infertility in Southwest Nigeria." *Health Transition Review*. No. 7. Pp. 205-220.

I. Postabortion Care

Prepared by Michal Avni, USAID, and Susan Settergren, Research Triangle Institute

Postabortion Care (PAC) involves the provision of emergency care services for complications caused by an incomplete spontaneous abortion (miscarriage) or by an unsafe induced abortion (pregnancy termination). PAC consists of three specific components: emergency treatment of complications, postabortion family planning counseling and services, and links between emergency PAC treatment and reproductive health care.

In general, most *gender* issues in PAC emerge from the circumstances that brought about an unwanted pregnancy and a subsequent clandestine termination. Women's difficulties in avoiding unwanted or mistimed pregnancies, the lack of women's legal access to a safe termination of a pregnancy, their need to resort to an unsafe and demoralizing 'medical' procedure, the secrecy and shame associated with it, and the legal ramifications—are all *gender* issues. However, since the focus here is on *postabortion* care, the analysis here begins further along the continuum of unwanted pregnancy and its sequelae.

This research exercise is designed to help guide USAID in its research agenda relevant to program design. Since USAID is currently involved only in postabortion care, we have limited this analysis to match existing projects. If the agency in the future were able to fund development activities that integrate abortion services with comprehensive reproductive health care, then a wider research gap analysis would be needed. Some gender questions which would need to be considered regarding abortion are:

- How do men and women communicate about an unwanted pregnancy? How do couples approach the subject of pregnancy termination, especially when abortion is illegal? How do they negotiate a decision? Who makes the decision?
- What elements influence client choice of abortion provider?
- How can the incidence of unsafe abortion be reduced where it is legal?
- How do race, culture, religion, literacy, legal system, SES, and other such factors affect women's access to abortion? How do they affect the quality of services women receive (including pain management)?
- What are the effects of increased male knowledge of modern contraception on the incidence of unwanted pregnancies and elective abortions?

Biomedical Research

This is the one area where a great deal of research *has* been conducted, especially having to do with the introduction of manual vacuum aspiration (MVA). Some gender issues addressed in research are:

- What impact do different technologies have on morbidity, mortality, and disability?
- Which contraceptive methods are appropriate for use post abortion?

Still needed:

- How does the use of different postabortion technologies affect access to services? Who is able to provide the technology?
- What is the incidence of complications and effectiveness (completeness of evacuation) of MVA technology when used by non-physicians?

Policy/Programmatic Research

- How is the decision made to take a woman suffering from postabortion complications to a health care facility?
- How can other gender-related barriers, such as travel/transportation, access, and resources, be mitigated?
- What are the gender-related issues that lead to discrimination or punitive treatment of PAC patients? What is the role of the sex of the provider in this?
- How does women's control over economic resources affect their access to postabortion care?
- Women often have little negotiating power (and low status within the family and the community) in decisions concerning whether, when, and where to seek postabortion services. Who are the gatekeepers to their health? How is the decision made to take a woman suffering from complications to a health care facility? Once a decision is made, what further barriers exist?
- What are the differences between male and female providers' attitudes toward family planning counseling at the site of PAC? What is the interplay between age (i.e. adolescent clients), marital status, and gender?
- How are women who seek PAC after a spontaneous abortion viewed? Does having had a pregnancy loss change their self-image as women or change the way they are perceived and treated by medical staff?
- What is the participation of male spouses or partners in PAC? How are they treated in the health care facility? How does the way they are treated affect timeliness of seeking emergency care for postabortion complications? (Some of these issues have been looked at in Kenya and Egypt, but more research is needed.)
- How does targeting/including men in PAC counseling and services affect female clients (as with family planning services, men play key decision making and support roles and must be considered as partners in PAC)?
- What differences, if any, exist in treatment of PAC for miscarriage (spontaneous abortion) vs. PAC for induced abortion? Are there differences in PAC patient treatment based on the gestational age at time of abortion?
- When accessing PAC services, are women with STIs/HIV treated differently from women who are not infected with STIs/HIV?
- Since one element of PAC services involves links to other reproductive health services, what is the relationship between effective PAC links and abortions related to/resulting from gender-based violence?

Social Science Research

- Are women with STIs/HIV treated differently from other women when accessing PAC services?

- How do gender factors affect the family planning continuation rates of clients who receive contraceptives as part of PAC?
- How can policy changes reduce the effects of early pregnancy on girls' schooling?
- How is law enforced? Laws typically punish/incarcerate women for illegal termination of pregnancy, not the men who got them pregnant or the providers of clandestine abortions. In cases where abortion is legal because the pregnancy resulted from rape or incest, the legal system is often so difficult to maneuver within that women cannot access the medical facility for a safe procedure.
- What are the effects of unsafe abortion and poor PAC on psychosexual health?
- What is the link between comprehensive family planning services at PAC and repeat abortion? What are the FP continuation rates of clients who receive contraceptives as part of PAC? (Some of this data is available in Mexico and Zimbabwe, but more research is needed.)

The Research Process

- In countries where abortion is illegal, to what extent is there a systematic denial of the magnitude of maternal morbidity and mortality resulting from unsafe abortion? To what extent does resistance to collecting data on the subject exist?
- It is very difficult to collect accurate data on abortion practices and complications due to the legal issues and cultural taboos associated with abortion. How extensive are underreporting and intentional misrepresentation of pregnancy history, and how do they affect the capacity to provide PAC?
- Does the fact that the allocation of resources and the setting of research priorities are typically controlled by male decision-makers influence the importance given to PAC?
- In many countries, health policy makers and other influential players have personal business involvements that make them subjective players in PAC. Does supporting PAC represent a conflict of interest for these individuals in terms of their roles in governments and professional societies? To what extent?
- What are the gender difficulties in conducting follow-up studies having to do with PAC?

Selected Bibliography

Most PAC materials focus on biomedical technology for treating incomplete abortions or on clinical discussion of complications. Few references address the gender issues associated with PAC.

Benson J. et al. 1992. "Meeting Women's Needs for Post-Abortion Family Planning: Framing the Questions." *Issues in Abortion Care 2*. Washington, DC: Ipas.

- Brazier E, Rizzuto R, Wolf M. 1998. *Prevention and Management of Unsafe Abortion: A Guide for Action*. New York: Family Care International.
- "Care for Postabortion Complications: Saving Women's Lives." 1997. *Population Reports*, Series L, Number 10, September 1997.
- The Center for Health Research. 1991. *Qualitative Research on Knowledge, Attitudes, and Practices Related to Women's Reproductive Health*. Consultation and Education (CIAES), MotherCare Project, Cochabamba, Bolivia.
- Germain A, Kim T. 1999. *Expanding Access to Safe Abortion: Strategies for Action*. NY: International Women's Health Coalition.
- Jacobson J. 1990. "Abortion in a New Light." *World Watch*, March-April 1990.
- McLarin KE, Senanayake P, Toubia N, Ladipo OA. 1995. "Post-Abortion Family Planning." *World Health Forum*, Volume 16, 1995.

J. Postmenopausal Women

Prepared by Jill Gay and Anne Peterson, Consultants

Gender and reproductive health issues relating to postmenopausal women have received little attention within the development community, although more than half of the world's women aged 60 years and older live in developing regions (WHO, 1996). However, the importance of these issues will only continue to grow as the number of postmenopausal women increases. "By the year 2020, one in five women in developing countries will be 50 or older... [but] the health problems of postmenopausal women... continue to be ignored" (World Bank, 1994). Health problems that have been the domain of industrialized countries, such as heart disease, osteoporosis and breast cancer, are increasing in the developing world as more women survive the early life span stages to reach middle age and post-menopause. For the women in developing countries who do reach middle age, their life expectancy approaches that of women in industrialized countries (WHO, 1996).

Circumstances that make menopause a different experience in the developing world, such as under-nutrition, repeated episodes of infectious disease and a lifetime of exposure to agricultural pesticides or indoor air pollution, have not been explored. In developing countries, nutritional deficiency of the general population is even more pronounced in aging women; years of child bearing and sacrificing her own nutrition for that of her family often lead to chronic anemia. And because of postmenopausal women's reduced importance in some cultures, improving a household's access to food does not guarantee that older women in the family will receive sufficient food or nutrition.

Postmenopausal women remain sexually active, although in some cultures it is a taboo subject, particularly for widows. The women in this group are still at risk of (and are) contracting STIs or HIV/AIDs, due in part to a lack of programs targeting reproductive health messages to them. The extension of basic literacy programs to aging women so they may reap the same reproductive health benefits as younger women would help in this regard. Often there is a reluctance by families to provide resources necessary for medical needs, and there are few reproductive health programs and few trained medical personnel addressing the needs of this cohort.

While the World Health Organization and the Pan American Health Organization have done literature reviews of the research pertaining to "Women of the Third Age," gender aspects of post-menopause research questions are a relatively new and uncharted challenge.

Biomedical Research

- What are the pharmacological differences in medications for postmenopausal women as compared to "standard" treatments? What are the norms? Are they explicit in reports of drug studies?
- What are the rates of HIV+ and RTIs among postmenopausal women in comparison with men of like age?

Policy/Programmatic Research

- What programs and policies have been effective in training providers to recognize chronic illnesses specific to postmenopausal women (such as heart disease) when currently such illnesses are believed by providers to be found mostly in men?
- What are effective programs and policies to increase access to health services (in terms of transportation, costs and work-related health benefits) for postmenopausal women?
- What programs and policies have been effective in enabling postmenopausal women to continue understanding the need for and making use of gynecological/reproductive health services for pap smears and breast exams?
- What programs empower postmenopausal women to continue to function, contribute to their societies, and encourage feelings of self-worth?
- What policies will increase the consumption of foods that contain high levels of calcium (which can reduce the incidence of osteoporosis) during a woman's lifetime?
- What are effective programs to institute support networks for widows?
- What programs are effective in providing women with exercise (to reduce obesity and diabetes) in dangerous urban settings where women work "the triple day"?
- Do health programs have preventive aspects that address the menopausal woman's issues, such as heart disease, sexual function, diabetes, hypertension, osteoporosis, etc.?
- How are women questioned about their sexuality and reproductive health? Are they told that healthy women can have sexual expression until death?
- Are providers trained to care for the information and treatment needs of aging couples, particularly in terms of their sexual expression?
- In what ways do policies contribute to (or detract from) seeing aging woman valuably within the culture?

Social Science Research

- What are effective ways to reach postmenopausal women with information and services relevant to their particular needs?
- What interventions can best address gender- and age-specific inequitable food distribution in the household?
- Are there active and effective support networks for postmenopausal women?
- Under what circumstances are postmenopausal women in a better position within their communities (political power, economic power, family power, etc.) than women of other age cohorts?
- Are women considered to be "sexual beings" after menopause? What are the advantages and disadvantages to the individual woman in her particular culture?

Selected Bibliography

Beyene Y. 1989. *From Menarche to Menopause: Reproductive Lives of Peasant Women in Two Cultures*. Albany, NY: SUNY Press.

- Harcourt W. 1997. *Power, Reproduction, and Gender: The Intergenerational Transfer of Knowledge*. London, UK: Zed Press.
- Institute of Medicine. 1996. *In Her Lifetime: Female Morbidity and Mortality in Sub-Saharan Africa*. Washington, DC: National Academy Press.
- Pan American Health Organization. 1990. *Perfil Epidemiológico de la Salud de la Mujer en la Región de las Américas*. Washington, DC: PAHO.
- World Bank. 1994. *A New Agenda for Women's Health and Nutrition*. Washington, DC: The World Bank.
- World Health Organization. 1996. *Women, Aging and Health: Achieving Health Across the Life Span*. Geneva: WHO.

K. Quality of Care

Prepared by Karen Hardee, POLICY Project, The Futures Group International

Most gender issues related to quality of care arise from the assumptions made by program staff about women's and men's preferences and need for information and services, and the unequal power relations between staff and clients. Prior to the movement to improve quality of care in family planning (and now in reproductive health), services were designed largely for the convenience of program staff, and women particularly were not considered competent to share in decisions related to their own care. In family planning programs, information given to clients on choice of methods, side effects, mechanisms of action, and follow-up care was generally not complete for fear of dissuading clients from using family planning. Furthermore, in many cases the language used by providers in interacting with clients was (and still is) condescending and disempowering. Finally, women's generally low status in most societies led family planning programs to be implemented for the purpose of lowering fertility (frequently by promoting female use of long-term and permanent contraceptive methods).

The current movement to improve quality of care seeks to empower clients to exercise their reproductive rights and meet their reproductive intentions. While quality of care has been the topic of a number of research studies, various gaps remain related to gender and each of the elements of quality of care: choice of methods, information provided to clients, interpersonal relations and use of language, technical competence, continuity of care, acceptability and appropriateness of care, and, in a closely related topic, access to care.

Biomedical Research

- How does current work in contraceptive development address changes in menstrual patterns related to contraceptive use?
- What is being done to develop methods that provide dual protection against conception and STIs/HIV?
- What efforts are being made particularly to develop women-controlled methods?
- Is the current guidance for service delivery guidelines (or standards of care) too focused on removing "medical barriers," and not adequately framed in the context of ensuring quality care for clients, which could result in under-medicalization of contraceptive care?
- Do treatments for bleeding changes and other side effects associated with contraceptive use affect women's acceptability of contraceptive methods?
- Has adequate scientific attention been given to developing male methods of contraception?

Policy/Programmatic Research

- Do providers consider female and male clients capable of being substantively involved in choices regarding their reproductive health care? How do providers treat female and male clients differently in terms of information

and care given?

- What assumptions do program planners make about the value of women's and men's time when designing services? How do service facilities deal with women's needs to care for their children while they are being examined? Or do they ignore this aspect of women's reality?
- Do program planners consult clients, both women and men, when designing or changing reproductive health services? Are program planners and staff concerned about clients' perspectives on the acceptability and appropriateness of care?
- Are female and male clients comfortable with the sex of the providers serving them?
- Does sex of provider make a difference to the information and care given to female and male clients?
- What kind of language do service providers use to address clients? Do they use the client's name during visits? Do they use first names or family names (e.g., Mrs./*Señora*)? Do they use diminutives in a lack of respect for the woman's own identity (such as dear, sweetie, honey, etc., in English or *mamita* and/or *mijita* in Spanish)? Do they offer their own name as a way to establish two-way communication?
- Is gender sensitive language used in written communication and IEC materials?
- Is language about women's reproductive rights used in written communication and IEC materials?
- Are health care staff making an effort to empower women to exercise their reproductive rights?
- Are programs to involve men in reproductive health working to redress the imbalance of power between men and women?
- Are efforts being made to improve the status of female providers within programs and to include more women in management positions?
- Are there programs in which men work as volunteers or are only women expected to work as volunteers?
- What are the best ways of reaching various social groups with reproductive health information and services?

Social Science Research

- How do definitions of quality of care in various societies differ by sex, social class and ethnicity?
- Do participatory approaches to reproductive health care improve the quality of services?
- How can women be empowered sufficiently to know what level of quality they should expect and demand?
- How do women and men receive information differently?

The Research Process

- Are female and male clients consulted in the design of intervention projects to improve quality of care?

- How could gender issues be incorporated into client satisfaction surveys?
- Are there better indirect methods to studying quality of care?
- How are nonusers and discontinuers included in quality of care studies?

Selected Bibliography

- Abdel-Tawab NG. *Provider-Client Communication in Family Planning Clinics in Egypt: Styles, Predictors and Associations with Client Outcomes*. Doctoral Dissertation. School of Hygiene and Public Health, Johns Hopkins University. Baltimore, Maryland. 242 p.
- Berer M. 1992. "Gender Issues in Quality of Care: Meeting Women's Reproductive Health Needs." Paper presented at the *IFFP Arab World Region Quality of Care Workshop*, London, 27-30 January.
- Bertrand J, Hardee K, Magnani RJ, Angle M. 1995. "Access, Quality of Care and Medical Barriers in Family Planning Programs." *International Family Planning Perspectives*. 21(2): 64-69.
- Bruce J. 1990. "Fundamental Elements of the Quality of Care." *Studies in Family Planning*. 21:61-91.
- Cotton N, J Stanback, H Maidouka, JT Taylor-Thomas and T Turk. 1992. "Early Discontinuation of Contraceptive Use in Niger and The Gambia." *International Family Planning Perspectives*. 18(4): 145-149.
- DiMatteo MR. 1994. "The Physician-Patient Relationship: Effects on the Quality of Health Care." *Clinical Obstetrics and Gynecology*. 37(1): 149-161.
- Hardon A. "Reproductive Rights in Practice: A Comparative Assessment of Quality of Care." In Hardon A and E Hayes. *Reproductive Rights in Practice: A Feminist Report on Quality of Care*. London: Zed Books. Pp. 193-222.
- Huntington D, Lettenmaier C, Obeng-Quaidoo I. 1990. "User's Perspective of Counseling Training in Ghana: The 'Mystery Client' Trial." *Studies in Family Planning*. 21(3): 171-177.
- International Planned Parenthood Federation/Western Hemisphere Region, Inc., with the assistance of Rosario Cardich, Judith F. Helzner, Magaly Marques, Jessie Schutt-Aine, and Victoria Ward. 2000. *Manual to Evaluate Quality of Care from a Gender Perspective*. New York: IPPF/WHO. January.
- Kay BJ, Germain A and Bangser M. 1991. "The Bangladesh Women's Health Coalition." *Quality/Calidad/Qualite*. 3:1-24.
- Kim YM, Kols A, and Mucheke S. "Informed Choice and Decision-Making in Family Planning Counseling in Kenya." *International Family Planning Perspectives*. 21(1): 4-11.
- Kols AJ and Sherman J. 1998. "Family Planning Programs: Improving Quality." *Population Reports*. Series J, No. 47. Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program. November.
- Matamala MI. 1998. "Gender-Related Indicators for the Evaluation of Quality of Care in Reproductive Health Services." *Reproductive Health Matters*. May.
- Mora G, Betts C, Gay J, Hardee K, Chambers V, and Fox L. 1993. *Quality of Care in Women's Reproductive Health: A Framework for Latin America and the Caribbean*. Draft. October 11.

- Murphy E. 1997. *Client-Provider Interaction*. Paper prepared for the CPI subgroup of the USAID MAQ Working Group.
- Pariani S, Heer DM, Van Arsdol J, and Maurice D. "Does Choice Make a Difference to Contraceptive Use? Evidence from Java." *Studies in Family Planning*. 22(6): 3384-390.
- Schuler SR, Choque ME and Rance S. 1994. "Misinformation, Mistrust, and Mistreatment: Family Planning Among Bolivian Market Women." *Studies in Family Planning*. 25(4): 211-221.
- Schuler SR, Hashemi SM, and Jenkins AH. 1996. "Bangladesh's Family Planning Success Story: A Gender Perspective." *International Family Planning Perspectives*. 21(4): 132-137.
- Schuler SR, McIntosh EN, Goldstein MC, and Pande BR. 1985. "Barriers to Effective Family Planning in Nepal." *Studies in Family Planning*. 16:260-270.
- Shelton JD, Angel MA and Jacobstein RA. 1992. "Medical Barriers to Access to Family Planning." *Lancet*. 340(8831): 1994-1335.
- Simmons R, and Elias C. 1994. "The Study of Client-Provider Interactions: A Review of Methodological Issues." *Studies in Family Planning*. 25(1): 1-17.
- Tavrow P, Namate D and Mpemba N. 1995. *Quality of Care: An Assessment of Family Planning Providers' Attitudes and Client-Provider Interactions in Malawi*. Draft. July.

L. Reproductive Health and Reproductive Rights

Prepared by Nancy Yinger, PATH, and Daniel Whelan, Consultant

There has been an increasing focus on gender, health, and human rights in recent years. The Cairo and Beijing conferences recognized that realization of the rights of women and men to the highest attainable standard of reproductive and sexual health is central to any population and development policy. A rights-based approach to health requires governments to accept accountability in the realization of health rights, implement legislative and judicial reforms, provide adequate support services, and promote a supportive environment for unprotected groups.

The literature on human rights and reproductive health remains largely conceptual and establishes that the current global and regional human rights regimes—treaties, statements, and mechanisms for redress—already contain the foundation on which a human rights approach to improving reproductive health can be built. The Cairo and Beijing Platforms have embodied these approaches within the language of “global consensus”; however, there are few specific goals on which programmatic activity can be based. Civil and political rights work, focusing on the passage or reform of legislation and the translation of those laws into practice at the local level, has also increased in recent years, especially in the realm of reducing violence against women and addressing the most severe violations (such as the eradication of FGC or the elimination of forced sterilization).

Beyond this conceptual work, there remain gaps in research looking at gender-related determinants of poor reproductive health *specifically from a human rights standpoint*. In particular, examination of gender-related discrimination as it pertains to women’s ability to access and utilize economic, social and political resources has only recently been recognized by both the reproductive health and human rights communities as critical for policies and programs to improve the reproductive and sexual health of women and men.

The main utility of a human rights approach is that governments can be held accountable to treaty obligations and other international commitments, such as the ICPD Programme of Action. These obligations can be mapped as a series of duties that government must undertake to protect a given right: 1) the duty to respect requires governments to refrain from active interference in the enjoyment of a right (including direct and coercive violations of rights); 2) the duty to protect requires governments to regulate the behavior of itself and its agents, and third actors (i.e., those other than itself or the individual who seeks to enjoy the right); and 3) the duty to promote and fulfill (or “facilitate”) requires governments to take a proactive approach toward ensuring the enjoyment of any and all human rights necessary for the enjoyment of the right in question, including the right itself. In human rights terms, the primary duty holders are states themselves, for they alone have the power to accede to human rights treaties and be scrutinized for their compliance with their norms.

Below is an illustrative list of the rights and issues relevant to improving women’s and men’s reproductive health, with an emphasis on research questions related to governmental obligations to protect, promote, and fulfill rights

necessary for reproductive health. Some areas, such as violence against women and female genital cutting (FGC), are covered elsewhere in this document. The rights listed below are found in the Universal Declaration of Human Rights (UDHR), and further expanded upon in the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social, and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); and the Convention on the Rights of the Child (CRC). A complete rights/reproductive health research agenda would define for each right whether people have the ability to fulfill this right and thus whether the government has fulfilled its duties, and if not, why, and how it could do so. The Rights/Obligation Framework at the end of this section shows a framework that could be used to develop a more complete research agenda, right by right.

Biomedical Research

Freedom from Human Experimentation

Right to fully informed consent in all trials related to contraceptive methods and/or drug treatments related to reproductive health

- Does the government set standards for human subject research that require full informed consent? How are those standards monitored and evaluated?

Attainment of the Highest Standard of Health

Obligation of governments to control endemic and epidemic disease

- Has there been research on how communicable diseases, particularly malaria, TB, and HIV/AIDS, affect women and men differently?

Policy/Programmatic Research

Right to Benefit from Scientific Progress

Access to reproductive health technologies and services (e.g., contraceptive methods, female condoms, treatment for STIs and RTIs, short-course AZT therapy for pregnant HIV-positive women)

- Are governments actively promoting policies concerning the allocation and availability of reproductive technologies that recognize the gender-related barriers women face in accessing services?
- Do governments set service-delivery standards that meet women's particular needs and ensure that health care workers treat clients with dignity and respect?

Ability to benefit from new findings in social research (e.g., gender-sensitive methods of HIV prevention)

- In implementing research programs and reproductive health policies, are governments taking into account new research and program evaluation data that would foster more gender-sensitive reproductive health policies and programs?
- Have government health officials received adequate training to recognize the gender-related elements of reproductive health policies and programs?

Right to Bodily Integrity

Freedom from mandatory or compulsory HIV and/or pregnancy testing

- Does the government have laws requiring or promoting mandatory testing of women for HIV or pregnancy? If so, what are the consequences for individuals who are pregnant or HIV-positive?
- If pregnancy/HIV testing is outlawed, how is the law implemented for private employers?

Freedom from forced sterilization or mandatory/coercive use of other long-term contraceptive methods.

- Are there laws against forced or coerced sterilization or other forms of contraception? If so, how are they enforced?

Attainment of the Highest Standard of Health

Right to a safe and healthy work environment

- Are there government standards for workplaces that protect the reproductive health of women, including standards on exposure to harmful biochemical products or waste?
- Is the home considered a workplace for women and is domestic environmental pollution included in the research agenda?

Access to basic health care services and information

- What strategies can reduce gender-related barriers to accessing reproductive health technologies and services?
- Has the inclusion of NGOs and women's groups increased accountability?
- What measures are effective for preventing coercion and promoting choice in reproductive health programs?
- Are the data on reproductive health of sufficient quality and gender sensitivity to monitor and or improve enforcement of rights to good health?
- Are health sector reforms having differential impact on men and women, in terms of the right of access to care?
- Have the linkages among poverty, ethnicity, residence and gender been assessed in terms of compounding factors that undermine people's achievement of their right to attaining the highest quality of health?
- Is adequate maternal care available? Does the government have a safe motherhood policy that recognizes women's special health needs during pregnancy and delivery?
- Have government-run clinics and other health care centers integrated the availability of reproductive health services where basic health care services are provided, to both women and men? Are the staff in those centers properly trained, including training in human rights to ensure that clients are treated with respect, dignity, privacy and confidentiality?

Obligation of governments to control endemic and epidemic disease

- Have governments taken appropriate (i.e., noncoercive) steps to reduce the incidence of new HIV and STI infections? Is the government taking

adequate measures to desegregate STI/HIV incidence/prevalence data by gender and age?

- How have research findings been used to take into account planning and delivery services?

Social Science Research

Freedom of Movement and Association

- What are the sociocultural norms that limit women's mobility outside the home? How do these norms directly impede women's ability to seek and receive reproductive health information and services?
- What sociocultural norms prohibit women from meeting together to discuss matters of importance to them, especially receiving information about reproductive health?

Access to Education and Training and Credit

Access to an Adequate Standard of Living

- How do public education curricula reinforce gender-stereotypical roles by offering different educational content to boys and girls?
- Have elements of the curriculum that foster gender stereotypes been removed?
- Are government-sponsored training programs designed to meet the special needs of women, in terms of time constraints and educational background?
- Is access to credit extended equally to women and men?
- Are women and men treated equally in all matters related to hiring, promotion, and firing in the workplace? Are women subjected to sexual forms of harassment?

Obligation to Alter the Conduct of Men and Women to Eliminate Gender Stereotypes

- How do government sponsored advertisements/promotions for reproductive health programs/services reinforce gender stereotypes?
- Do government programs urge men to seek reproductive health services as adamantly as they do women?

Rights/Obligations Framework

This matrix (see page 49) allows any reproductive or sexual health right to be broken down according to the range of duties and obligations of governments under international human rights standards. The example used here is the right to choose family size/spacing and enjoy the highest attainable standard of reproductive and sexual health—defined more broadly than freedom from disease or infirmity—without fear of coercion, violence or discrimination.

Each duty is contextualized with reference to the right listed in the first column. The duty to respect requires governments to refrain from active interference in the enjoyment of a right (including direct and coercive violations of rights). The duty to protect requires governments to regulate the behavior of itself and its agents, and third actors (i.e., those other than itself or the individual who seeks to enjoy the right). The duty to promote and fulfill (or “facilitate”)

requires governments to take a proactive approach toward ensuring the enjoyment of any and all human rights necessary for the enjoyment of the right in question, including the right itself.

This example takes one widely defined right and lists several examples of research questions that could be explored in order to evaluate the level of compliance or violation. In this case, we refer to “information, services and technologies” for individuals and couples to “freely and responsibly choose” the number and spacing of their children. Information can refer to printed literature in word or pictogram formats or to orally delivered information. These are meant to provide examples of questions. A full list of questions should be determined after conducting preliminary qualitative data collection to determine the context of people’s experiences with their ability to realize this right.

The information must be accurate and not reinforce negative gender or other stereotypes. The information must be comprehensive, and not be biased against any particular method that may be available (e.g., only offering information about withdrawal and rhythm and not discussing barrier methods or the pill). Services refer to exams, consultations and procedures, such as appropriate IUD insertion. Technologies refers to the various methods of family planning (e.g., pills, condoms, DEPO, diaphragms, injections, vasectomy) and other treatments for reproductive health.

RIGHTS/OBLIGATIONS FRAMEWORK			
Reproductive/ Sexual Right	Duty to Respect	Duty to Protect	Duty to Promote/Fulfill
<p>Right of women and men to information, technologies, and services so they can freely and responsibly choose the number and spacing of their children.</p>	<p>Do laws, policies, or practices actively deny or impede the flow of information, services, and/or technologies that would otherwise be available?</p> <p>Example: Are NGOs or other donors allowed to operate or freely provide appropriate information, services and/or technologies to those who need them without governmental interference?)</p> <p>Example: Do laws or policies expressly prohibit the provision of reproductive health information to adolescents in schools?</p>	<p>Does the government act positively through its laws, policies, or practices to ensure that powerful third actors do not undermine this right of men and women?</p> <p>Example: Do laws, policies and practices ensure that employers allow employees appropriate time to seek out proper reproductive health information, services or technologies?</p> <p>Example: Does the government ensure that projects/ programs supported by non actors (such as the World Bank) do not interfere with women's and men's ability to realize this right?</p>	<p>Does the government take positive legislative, administrative, policy, or programmatic action to ensure women and men can realize this right?</p> <p>Example: What actions have been taken by the government to address sociocultural norms that limit women's mobility outside the home?</p> <p>Example: What actions have been taken by the government to ensure that hours of operation and distance from the home are addressed to meet the needs of women?</p> <p>Example: Does the government ensure that the widest possible range of reproductive technologies are made available at the lowest possible cost to all who need them?</p> <p>Example: Has the government taken steps to ensure that men are able to participate responsibly in the family planning process by providing information and services for such responsible behavior to emerge?</p>

Selected Bibliography

- The American University Law Review. 1995. "Proceedings of the Conference on the International Protection of Reproductive Rights." *American University Law Review* 44(4).
- Yamin AE. 1996. "Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law," *Human Rights Quarterly*. 18: 398-438.
- Boland R. 1997. *Promoting Reproductive Rights: A Global Mandate*. New York: Center for Reproductive Law and Policy.
- Center for Reproductive Law and Policy. 1995. *Women of the World: Formal Laws and Policies Affecting their Reproductive Lives* (A set of volumes covering different countries).
- Copelon R, Gruskin S, and Toubia N. 1996. "Toward More Effective Implementation of Women's Human Right to Health, with a Focus on Reproductive and Sexual Rights: A Proposal for Collaboration Among Human Rights Treaty Bodies, Agency and NGO Experts to Integrate the ICPD/Beijing Consensus into the Work of the Human Rights Treaty Bodies." Background Paper for the *Roundtable of Human Rights Treaty Bodies on Human Rights Approaches to Women's Health, with a Focus on Reproductive and Sexual Health Rights*, Glen Cove, NY, 8-11 December 1996.
- Cook R. 1993. *Human Rights in Relation to Women's Health*. Geneva: World Health Organization.
- Cook RJ and Fathalla MF. 1996. "Advancing Reproductive Rights Beyond Cairo and Beijing." *International Family Planning Perspectives*. 22(3): 115-121.
- Cook RJ. 1997. "Advancing Safe Motherhood Through Human Rights." Presented at *Safe Motherhood Matters: 10 Years of Lessons and Progress: A Technical Consultation*. October 18-23, Colombo, Sri Lanka.
- Petchesky R. 1995. "From Population Control to Reproductive Rights: Feminist Fault Lines," *Reproductive Health Matters*. 6:52-161.
- Petchesky R, Judd K, Eds. 1998. *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures*. International Reproductive Rights Research Action Group (IRRRAG). New York: Zed Books.
- Tarantola D, Gruskin S. 1998. "Children Confronting HIV/AIDS: Charting the Confluence of Rights and Health." *Health and Human Rights*. 3(1): 60-86.
- United Nations, Commission on the Status of Women. *Follow-up to the Fourth World Conference on Women: Implementation of Strategic Objectives and Action in the Critical Areas of Concern*. Report to the Secretary General, E/CN.6/1999/4.
- UNFPA, UNDAW, and UNHCHR. 1998. *Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women's Health, with a Focus on Sexual and Reproductive Health and Rights*. UNFPA.
- UNFPA. 1998. *A Focus on Population and Human Rights*.
- UNFPA. 1998. *Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes Including Women's Empowerment, Male Involvement and Human Rights*. Report of an Expert Roundtable Meeting, Kampala, Uganda, 22-25 June 1998.
- Whelan D. 1998. *Recasting WID: A Human Rights Approach*. Washington, DC: International Center for Research on Women.

-----, 1998. "Human Rights Approaches to an Expanded Response to Address Women's Vulnerability to HIV/AIDS." *Health and Human Rights*. 3(1): 20-36.

M. Safe Motherhood

Prepared by Anne E. Peterson, Consultant

The gender issues surrounding safe motherhood (prenatal care, safe delivery, postnatal care, and breastfeeding) are more difficult to define than for infertility or STI, because only women can become pregnant, go through the birthing process and breastfeed. This is not to say, however, that the issues surrounding pregnancy, childbirth, and the postpartum period are not linked to gender, or that gender considerations are not important for these issues. As with postabortion care, many of the gender issues in prenatal care, safe delivery, postnatal care, and breastfeeding could arise from the circumstances that brought about the pregnancy in the first place: women's lack of power with her partner, lack of access to contraception and/or other health care services, under-education when compared with male counterparts in the same society, etc.

What also makes the prenatal care issue particularly difficult is that there are no good predictive indicators of at-risk pregnancies, although this topic has been studied extensively. Because of this, all pregnancies must be considered at risk. However, there are ongoing studies concerning community and/or family empowerment through community knowledge of danger signs during pregnancy.

There is evidence of the impact men have on issues such as attaining prenatal care in a timely manner, decisions about transportation and how this affects timeliness of transport in emergencies, and the propensity to breastfeed. The importance of the male partner's role in allocation of family resources, for pre- and postnatal care and transport issues, cannot be underestimated and needs further attention. Other gender issues, such as the fact that in some cultures the husband must be involved in placenta rituals keeping the woman from seeking medical care away from the village, also need further recognition and study. To date, however, a majority of the research on gender implications surrounding prenatal care, safe delivery, postnatal care and breastfeeding has been conducted in and focused on the industrialized world, and more specifically, breastfeeding in industrialized countries. There is a need to direct future research on prenatal care, safe delivery, postnatal care and breastfeeding towards developing countries, concentrating on the cultural constraints gender imposes for each topic.

Policy/Programmatic Research

- What can be done to increase women's access to resources so they may achieve proper pre- and postnatal care and have access to services for safe deliveries?
- What are the differences between male and female providers in how, how often, and the types of pre- and postnatal services that are suggested and/or rendered to women?
- How can programs promote male involvement in pre- and postnatal care, safe delivery, and breastfeeding while promoting and maintaining women's autonomy?
- How do male partner's feelings about a pregnancy (wants to have a child/doesn't want to have a child) affect prenatal services the mother

receives?

- How can effective IEC campaigns be designed, for both men and women, which outline and encourage proper medical treatment/appointments that correspond to the needs of the pregnant/newly postpartum woman and her partner?
- Are men allowed to/encouraged to/demanded to participate in the birth process with their partner/wife? Do women have autonomy in this decision?
- Are women free to choose whether their partner/husband participates in the childbirth process?
- How does the sex of the service provider determine whether breastfeeding occurs immediately postpartum? And/or if the Lactational Amenorrhea Method (LAM) is offered as an option for postpartum contraception?
- What legislative initiatives have been effective in allowing working women to breastfeed?
- What nutritional programs have been effective in providing women adequate nutrition during pregnancy and during postpartum breastfeeding?
- What can be done to reduce the high rate of elective caesarian section births (those being done for reasons other than life-saving/emergency reasons) occurring in developing countries, particularly in Latin America?
- How can continuing education programs for girls, who have become pregnant and have been forced to leave school, be successfully replicated?

Social Science Research

- How do societal/cultural ideas about where/how a birth should take place affect transport issues, particularly during emergencies? How can these ideas be positively altered?
- How are decisions made within a family to provide the resources for pre- and postnatal services, and/or for emergency transportation if necessary?
- How can communities be encouraged to change cultural practices and gender norms to enable pregnant women to receive a nutritional diet?
- What are ways of encouraging communities to reduce gender inequities in order to improve girl children's nutrition?
- How does a woman's status and role within the family/community affect how she will be treated during pregnancy?
- What are the differences between men's and women's attitudes towards the importance of prenatal care, safe delivery, postnatal care and breastfeeding? How do these attitudes affect the care received by women during and after pregnancy?
- What societal conditions allow women to feel comfortable breastfeeding at work, in public, etc.?
- What training is effective to promote male support for breastfeeding and male involvement to reduce women's traditional chores, thereby enabling breastfeeding?
- What are the effects of lack of pre- or postnatal care, an unsafe delivery, or lack of breastfeeding on the psychosexual health of the mother?

Selected Bibliography

- Campero L, Garcia C, Diaz C, Ortiz O, Reynoso S, Langer A. 1998. "‘Alone, I Wouldn’t Have Known What to Do’: A Qualitative Study on Social Support During Labor and Delivery in Mexico." *Social Science and Medicine*. 47(3):395-403.
- D’Ascoli PT, Alexander GR, Petersen DJ, Kogan MD. 1997. "Parental Factors Influencing Patterns of Prenatal Care Utilization." *Journal of Perinatology*. 17(4):283-7.
- Fortney JA, Susanti I, Gadalla S, Saleh S, Feldblum PJ, Potts M. 1988. "Maternal Mortality in Indonesia and Egypt." *International Journal of Gynaecology and Obstetrics*. 26(1):21-32.
- Freed GL, Fraley JK, Schanler RJ. 1992. "Attitudes of Expectant Fathers Regarding Breast-feeding." *Pediatrics*. 90: 224-7.
- George N. 1990 *Interventions to Improve Maternal and Neonatal Health and Nutrition*. Mother Care Working Paper #4. Arlington, VA: John Snow, Inc.
- Giugliani ER, Bronner Y, Caiaffa WT, Vogelhut J, Witter FR, Perma JA. 1994. "Are Fathers Prepared to Encourage their Partners to Breastfeed? A Study About Fathers’ Knowledge of Breastfeeding." *Acta Paediatrica*. 83(11):1127-31.
- Koblinsky MA, Tinker A, Daly P. 1993. "Programming for Safe Motherhood: A Guide to Action." *Health Policy and Planning*. 9(3): 252-266.
- Kwast, BE. 1993. "The Role and Training of Midwives for Safe Motherhood" in *The Current Status of Gynaecology and Obstetric Series* (from The Proceeding of the XIIIth World Congress of Gynaecology and Obstetrics). 6:173-182.
- Kwast BE. 1996. "Reduction of Maternal and Perinatal Mortality in Rural and Peri-Urban Settings: What Works?" *European Journal of Obstetrics and Gynecology and reproductive Biology*. 69:47-53.
- Li XF, Fortney JA, Kotelchuck M, Glover LH. 1996. "The Postpartum Period: the Key to Maternal Mortality." *International Journal of Gynaecology and Obstetrics*. 54(1):1-10.
- Schaffer MA, Lia-Hoagberg B. 1997. "Effects of Social Support on Prenatal Care and Health Behaviors of Low-Income Women." *Journal of Obstetrical Gynecological and Neonatal Nursing*. 26(4):433-40.
- Schieber B, Delgado H. 1993. *An Intervention to Reduce Maternal and Neonatal Mortality*. Quetzaltenango, Guatemala: MotherCare and INCAP.
- Scott JA, Binns CW, Aróni RA. 1997. "The Influence of Reported Paternal Attitudes on the Decision to Breastfeed." *Journal of Paediatric and Child Health*. 33(4):305-7.
- Tinker A, Koblinsky MA. 1993. *Making Motherhood Safe*. Washington, DC: The World Bank.
- Zambrana RE, Dunkel-Schetter C, Scrimshaw S. 1991. "Factors Which Influence Use of Prenatal Care in Low-Income Racial-Ethnic Women in Los Angeles County." *Journal of Community Health*. 16(5): 283-95.

N. Violence Against Women

Prepared by Rebecca Firestone, Mary Ellsberg, and Lori Heise, CHANGE

Well-conducted research on gender-based violence is vitally important to efforts to combat violence and to create an environment in which women can fully exercise their rights to health and safety. A greater understanding of violence against women within and across cultures will facilitate the design of cost-effective and appropriate prevention, intervention and treatment programs, and will galvanize efforts to address gender-based abuse.

Biomedical Research

A growing body of evidence has shown that violence against women represents a significant health burden for women and one that has substantial implications for women's health care utilization. Increased reliance on epidemiological and longitudinal study designs is necessary to better establish links between violence and various health outcomes. Specifically:

- What is the impact of violence and sexual coercion on women's sexual and reproductive health, including STIs, HIV/AIDS, fertility, and maternal health?
- How do partner abuse and violence against women affect children's health?
- How much of the overall mental health burden (including PTSD, depression and anxiety disorders) among women can be attributed to victimization?
- What proportion of female homicide, suicide and nonfatal injury is related to physical and/or sexual abuse?

Policy/Programmatic Research

As attention to violence against women has increased, many different types of interventions have been implemented. Interventions range from community mobilization and women's empowerment techniques to criminal justice reform, training for health care workers, and outreach to clergy. Assessment of program outcomes is necessary to ascertain the possibility of replication and to inform policy-making. Research needs include:

- Documentation of the range of interventions being tried in different settings.
- Development of indicators and outcome variables that are appropriate and feasible for measuring the impact of interventions.
- Formative and diagnostic research using techniques such as participatory rapid appraisal (PRA) and focus groups to guide the design and implementation of interventions.

Specifically:

- How effective are referral systems and programs to integrate violence-prevention and detection into health-care systems?
- What are the costs, in financial and human development terms, of domestic violence and sexual assault in relation to women's lost wages/productivity, increased public sector spending and decreased participation of women in local and national development (economic, social and community development, political participation)?

- What are the links between violence and women's health-seeking behavior and between violence and use of contraception?

Social Science Research

- What are the dynamics, triggers, and social context of intimate partner abuse in developing country contexts?
- How do constructions of femininity and masculinity at the family and societal levels contribute to or mitigate abuse?
- What are the links between violence and women's health-seeking behavior and between violence and use of contraception?
- More population-based surveys are needed to give an accurate picture of the prevalence of abuse and produce data that are comparable across settings. Especially lacking are data on sexual coercion and the prevalence of child sexual abuse in developing countries.
- More research into the theoretical foundations of violence and factors at the individual, family, community and societal levels that increase women's risk can contribute to a better understanding of causality.
- What is the relationship between violence and alcohol and/or substance use?

The Research Process

Because of the sensitive nature of abuse, researching violence against women raises multiple ethical and methodological issues. Poorly conceptualized, designed or conducted studies can potentially endanger the safety of participants, fieldworkers and/or researchers and can compromise data quality. High-quality and ethically derived data will require:

- New and better instruments for measuring the prevalence, severity and health consequences of abuse. The instruments must be derived and validated.
- That existing instruments be evaluated for their accurate comprehension by men and women respondents.
- Further methodological research to assess whether and how issues such as question wording and the characteristics of the interviewers affect rates of disclosure.
- More integrated research strategies that draw on the combined strengths of both qualitative and quantitative research methodologies.

Selected Bibliography

- Ellsberg M, Liljestrand J, and Winkvist A. 1997. "The Nicaraguan Network of Women Against Violence: Using Research and Action for Change." *Reproductive Health Matters*. 10: 82-92.
- Ellsberg M, Pena R, Herrera A, Liljestrand J, and Winkvist A. 1999. "Candies in Hell: Women's Experiences of Violence in Nicaragua." *Social Science and Medicine* (forthcoming).
- Ellsberg M, Pena R, Herrera A, Liljestrand J, and Winkvist A. 1999. "Wife Abuse Among Women of Childbearing Age in Nicaragua." *American Journal of Public Health*. 89(2): 241-244.

- Heise L, Moore K and Toubia N. 1995. *Sexual Coercion and Reproductive Health: A Focus on Research*. New York: Population Council.
- Heise LL, Raikes A, Watts CH, Zwi AB. 1994. "Violence Against Women: A Neglected Public Health Issue in Less Developed Countries." *Social Science and Medicine*. 39(9): 1165-79.
- Heise L. 1998. "Violence Against Women: An Integrated, Ecological Framework." *Violence Against Women*. 4(3): 262-290.
- Heise, L, Ellsberg, M. and Gottemoeller, M. 1999. "Ending Violence Against Women." *Population Reports*, Series L, No. 11. Baltimore, Johns Hopkins University School of Public Health, Population Information Program, December.
- International Research Network on Violence Against Women. 1998. *Summary Report of the Third Annual Meeting*, January 9-11, 1998, Center for Health and Gender Equity, Washington, DC.
- Johnson H. 1996. *Dangerous Domains: Violence Against Women in Canada*. Toronto: Nelson Canada.
- Swiss S, Jennings PJ, Aryee GV, Brown GH, Jappah-Samukai RM, Kamara MS, Schaack RDH, Turay-Kanneh RS. "Violence Against Women During the Liberian Civil Conflict." *JAMA*. 279: 625-629.

O. Other Topics

As the Research and Indicators Subcommittee worked through the topics for this document, there were a couple of issues that did not fit well into the identified sections, but that were too narrow to have an entire section devoted to the topic. These issues are too important, however, to be omitted entirely from this document:

- What factors lead to sex selection against the girl fetus? What can be done to reduce/halt this practice from occurring in some cultures?
- How are programs to involve men in reproductive health working to redress the imbalance of power between men and women?

Priorities Matrix

Priorities for research relating to gender and reproductive health are presented in a matrix form (on the following several pages) that follows the design of this document. Members of the Research and Indicators Subcommittee voted to prioritize the research gaps listed in each section, and the identified research gap(s) receiving the most votes was placed into the matrix.

Identified Priorities for Research Gaps Relating to Gender & Reproductive Health

A. ADOLESCENTS			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> To what extent does the immature female genital tract make adolescent girls more susceptible to RTIs/STIs? 	<ul style="list-style-type: none"> What barriers do young women face in using modern-sector reproductive health (RH) services (government, NGO and commercial) – family planning, STIs, safe mother-hood, PAC? Do service providers particularly discriminate against young, unmarried, sexually active women? What barriers do young men face in using modern sector RH services – family planning, STIs? Are the barriers faced by young men different than those faced by young women? Do very young adolescents face different barriers than older adolescents? How do fees-for-service affect adolescent women's and men's use of RH services differently? What RH services do adolescent women and men perceive they need? Have adolescent women and men been involved in the research process in a participatory way? Have both qualitative and quantitative techniques been used to get an in-depth understanding of their needs? 	<ul style="list-style-type: none"> Do adolescent women and men make decisions differently about RH-related issues? What is the balance between individual calculations and outside influences for males and females?
B. BEHAVIOR CHANGE COMMUNICATION			
Research Area		<ul style="list-style-type: none"> How do existing behavior change communication programs address gender roles and status in the communities and societies where they are in place? What effects do BCC programs have on existing gender norms within communities and societies? How do BCC programs with women's empowerment and gender equity components address or defuse potential community resistance? How successful are communications programs that focus on changing or clarifying values in support of gender equity? 	<ul style="list-style-type: none"> How do mass media, as used in reproductive health and social marketing programs, affect gender images and norms? How do the political and social factors necessary to create a supportive environment for behavior change differ between women and men?

C. CHILD SURVIVAL			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> How do pharmacological differences in medications for girl children as compared to boy children affect reproductive health later in life? Does pesticide poisoning during childhood lead to adverse reproductive health problems later in the life cycle? 	<ul style="list-style-type: none"> What are effective ways for health services to encourage gender equitable treatment of girl and boy children? Specifically, <ul style="list-style-type: none"> When children are gathered for immunization, how can community members and health workers be motivated to seek out the girls, who may be at home? How can health services be changed to encourage outreach to girl children for necessary prevention and care? What can encourage community members important to children to be knowledgeable about and discuss the issues of sexuality and the psychological/physiological/emotional changes that occur during puberty? What are effective ways to teach mothers/fathers/teachers/community members important to children the knowledge they need to discuss sexuality/puberty? What are ways of encouraging communities to reduce gender inequities in order to improve girls' nutrition? 	<ul style="list-style-type: none"> What factors lead to uneven/ inequitable distribution of food in the household? What impact does this have on reproductive health later in life? What programs can best effect change in this area? What factors contribute to inequitable health resources for girls as compared to boys?
D. ENVIRONMENTAL AND OCCUPATIONAL HEALTH			
Research Area	<ul style="list-style-type: none"> How does the prevalence of anemia in women impact on the reproductive health risks of environmental and occupational exposures? Are there any reproductive health impacts from exposure to air pollution? 	<ul style="list-style-type: none"> What are the most effective ways to provide women and girl children, particularly those who are illiterate, with training concerning the reproductive health hazards of pesticide exposure? What are effective ways to train health service providers to recognize and treat occupational, environmental or pesticide-related etiologies during reproductive health care? 	<ul style="list-style-type: none"> What are the numbers of women and girl children at risk of pesticide exposure with concomitant reproductive health risks? Which crops, tasks, gendered roles and pesticides place women and girls most at risk? Men and boys? Which occupational and domestic tasks involve differential reproductive health risks for women and men?

E. FEMALE GENITAL CUTTING			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> Are women who have had FGC more likely to contract HIV/AIDS? What are the long-term physical effects of FGC for women? 	<ul style="list-style-type: none"> What are the consequences of dealing with FGC in isolation of other gender issues? What is the relationship between family planning and FGC? 	<ul style="list-style-type: none"> Is there a difference in the way men and women approach the issue of FGC? What is the best way to address these differences? What are the reasons behind male reluctance to get involved in combating FGC?
F. HIV/AIDS/STIs AND CONDOM USE			
Research Area	<ul style="list-style-type: none"> What incentives can lead to more pharmaceutical products to meet women's needs for cheap, easy methods to detect asymptomatic STIs? What incentives can lead to more pharmaceutical products to meet women's needs to prevent HIV without a partner's knowledge or consent? How can the progress to develop a cheap, easy to use mechanism to identify cervical infections be accelerated? 	<ul style="list-style-type: none"> What are effective ways to involve women and their sexual partners in HIV risk reduction and to maintain risk reduction practices over sustained periods of time? How can the norms of sexual behavior be changed so that: <ul style="list-style-type: none"> Men, women, and their sexual partners can discuss sexual relationships prior to intercourse? Nonconsensual sexual relationships are reduced? Women can initiate and enjoy sexual relationships? Risk of acquiring STIs and HIV is reduced? What is the most effective way to provide non-punitive, noncoercive health services to commercial sex workers that will not result in stigmatization? 	<ul style="list-style-type: none"> What are the differences between successful and unsuccessful condom users; both female and male condoms, both heterosexual and homosexual? Do gender issues inhibit the use of condoms used in conjunction with other methods?
G. INFECTIOUS DISEASE AND REPRODUCTIVE HEALTH			
Research Area	<ul style="list-style-type: none"> How can the increased susceptibility of pregnant women to malaria be reduced? What is the biologic interaction between malaria infection and HIV infection during pregnancy? What does this mean for treatment? 	<ul style="list-style-type: none"> What are effective ways to give women and girls knowledge of infectious diseases, especially malaria, prior to their first pregnancy? 	<ul style="list-style-type: none"> What training is effective to promote male support for breastfeeding and male involvement to reduce women's traditional chores to enable breastfeeding? What are current beliefs among different populations concerning infectious diseases, such as malaria and TB, during pregnancy? Are these beliefs different for men and for women? Are patterns of drug distribution different for men and for women for malaria, TB, or other infectious diseases, especially when a woman is pregnant?

H. INFERTILITY			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> What types of clinical trials for infertility treatments are being undertaken in developing countries? What research is being done to study the effects of women's and men's exposure to environmental pollutants on fertility? More specifically, is exposure to endocrine disrupters identified as a source of infertility for both men and women? 	<ul style="list-style-type: none"> To what extent are STIs recognized as causes of infertility for both women and men? How does gender influence access to inexpensive treatments for both female and male factor infertility (such as penicillin for the main STIs gonorrhea and chlamydia)? What are the most promising efforts being made to reduce STIs, PID and associated infertility in women and men in various countries? What populations are they reaching? How successful are these efforts? 	<ul style="list-style-type: none"> What are the social consequences of infertility for women and men in various societies? What are women's, men's and families' coping strategies for dealing with infertility in various countries? What are the perceptions of various groups (policymakers, opinion leaders, providers, the public) of the causes of and treatments for infertility? What is the link between the value men and women place on fertility and use of various contraceptive methods?
I. POSTABORTION CARE			
Research Area	<ul style="list-style-type: none"> How does the use of different postabortion technologies affect access to services? What is the incidence of complications and effectiveness (completeness of evacuation) of MVA technology when used by non-physicians? 	<ul style="list-style-type: none"> How is the decision made to take a woman suffering from postabortion complications to a health care facility? How can other gender-related barriers, such as travel/transportation, access, and resources be mitigated? What are the gender-related issues that lead to discrimination or punitive treatment of PAC patients? What is the role of the sex of the provider in this? 	<ul style="list-style-type: none"> How do gender factors effect the FP continuation rates of clients who receive contraceptives as part of PAC? How can policy changes reduce the effects of early pregnancy on girls' schooling?
J. POSTMENOPAUSAL WOMEN			
Research Area	<ul style="list-style-type: none"> What are the pharmacological differences in medications for post-menopausal women as compared to "standard" treatments? What are the norms? Are they explicit when reporting on drug studies is done? What are the rates of HIV+ and RTIs among post-menopausal women, in comparison with men of like age? 	<ul style="list-style-type: none"> What programs and policies have been effective in enabling post-menopausal women to continue understanding the need for and attending gynecological/reproductive health services for pap smears and breast exams? What are effective programs and policies to increase access to health services (both in terms of transportation, costs and work-related health benefits) for post-menopausal women? 	<ul style="list-style-type: none"> What are effective ways to reach post-menopausal women with information and services relevant to their particular needs? What interventions can best address gender-and age-specific inequitable food distribution in the household?

K. QUALITY OF CARE			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> How does current work in contraceptive development address changes in menstrual patterns related to contraceptive use? What is being done to develop methods that provide dual protection against conception and STIs/HIV? What efforts are being made particularly to develop women-controlled methods? 	<ul style="list-style-type: none"> Do providers consider female and male clients capable of being substantively involved in choices regarding their reproductive health care? How do providers treat female and male clients differently in terms of information and care given? 	<ul style="list-style-type: none"> How do definitions of quality of care in various societies differ by sex, social class, and ethnicity? Do participatory approaches to RH care improve the quality of services? How can women be empowered sufficiently to know what level of quality they should expect and demand?
L. REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS			
Research Area		<ul style="list-style-type: none"> What strategies can reduce gender-related barriers to accessing RH technologies and services? Has the inclusion of NGOs and women's groups increased accountability? What measures are effective for preventing coercion and promoting choice in RH programs? 	<ul style="list-style-type: none"> How do public education curricula reinforce gender-stereotypical roles by offering different educational content to boys and girls? How do government-sponsored advertisements/promotions for reproductive health programs/services reinforce gender stereotypes?
M. SAFE MOTHERHOOD			
Research Area		<ul style="list-style-type: none"> What can be done to increase women's access to resources so they may achieve proper pre- and postnatal care and have access to services for safe deliveries? What are the differences between male and female providers in how, how often, and the types of pre- and postnatal services that are suggested and/or rendered to women? 	<ul style="list-style-type: none"> How do societal/cultural ideas about where/how a birth should take place effect transport issues, particularly during emergencies? How are decisions made within a family to provide the resources for pre- and postnatal services, and/or for emergency transportation if necessary? How does a woman's status and role within the family/community effect how she will be treated during pregnancy?

N. VIOLENCE AGAINST WOMEN			
	Biomedical	Policy/Programmatic	Social Science
Research Area	<ul style="list-style-type: none"> What is the impact of violence and sexual coercion on women's sexual and reproductive health, including RTIs, HIV/AIDS, fertility, and maternal health? How do partner abuse and violence against women effect children's health? 	<ul style="list-style-type: none"> How effective are referral systems and programs to integrate violence-prevention and detection into health-care systems? What are the costs, in financial and human development terms, of domestic violence and sexual assault in relation to women's lost wages/productivity, increased public sector spending and decreased participation of women in local and national development (economic, social and community development, political participation)? 	<ul style="list-style-type: none"> What are the dynamics, triggers, and social context of intimate partner abuse in developing country contexts? How do constructions of femininity and masculinity at the family and societal levels contribute to or mitigate abuse? What are the links between violence and women's health-seeking behavior and between violence and use of contraception?
O. OTHER TOPICS			
Research Area		<ul style="list-style-type: none"> How are programs to involve men in reproductive health working to redress the imbalance of power between men and women? 	<ul style="list-style-type: none"> What can be done to reduce/halt the practice of selective abortions to female fetuses occurring in some cultures?